



## Eastern Illinois Area Of Special Education

5837 Park Drive • Charleston, IL 61920  
 Phone: 217-348-7700 Fax: 217-348-7704

### OFFICE USE ONLY

Date Received EIASE: \_\_\_\_\_

Copies To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## REFERRAL FOR AUDIOLOGICAL SERVICES

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M F \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_ Phone: Home ( ) \_\_\_\_\_  
 Phone: Work ( ) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Resident School District \_\_\_\_\_ County \_\_\_\_\_

School Attending \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

School Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ School Telephone \_\_\_\_\_

**Handicap:** Please check the child's primary handicapping condition as indicated by the special education placement. (One per child).

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> A. TMH                    | <input type="checkbox"/> H. Deaf/Blind                | <input type="checkbox"/> S. Non-Categorical-Diagnostic     |
| <input type="checkbox"/> B. EMH                    | <input type="checkbox"/> I. Speech and Language       | <input type="checkbox"/> T. Early Childhood (non-specific) |
| <input type="checkbox"/> C. Physically Handicapped | <input type="checkbox"/> J. Educationally Handicapped | <input type="checkbox"/> U. 0-3 (non-specific)             |
| <input type="checkbox"/> D. Learning Disabled      | <input type="checkbox"/> K. Behavior Disordered       | <input type="checkbox"/> V. Autistic                       |
| <input type="checkbox"/> E. Visually Impaired      | <input type="checkbox"/> L. Other Health Impaired     | <input type="checkbox"/> W. None                           |
| <input type="checkbox"/> F. Hard of Hearing        | <input type="checkbox"/> M. Multi-Handicapped         | <input type="checkbox"/> X. Not Known                      |
| <input type="checkbox"/> G. Deaf                   |   |  |

Describe the child's specific problem and/or behavior: \_\_\_\_\_  
 \_\_\_\_\_

Give reason for referral (e.g. What questions do you want answered?) \_\_\_\_\_  
 \_\_\_\_\_

Other agencies aware of or providing services for the child (DSCC, IDPA, DCFS, etc.) \_\_\_\_\_

Child's natural spoken language or other mode of communication: \_\_\_\_\_

### SIGNATURES REQUIRED

I hereby give consent for EIASE Audiology to receive the information listed above and for the evaluations/service to be performed, for my child \_\_\_\_\_. I understand that this voluntary consent is not final and that these evaluations can be discontinued by my submitting a letter for termination to EIASE Audiology.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Person Referring Child \_\_\_\_\_ Date \_\_\_\_\_

Signature of Principal \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Signature of Director of Special Education \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_