



Eastern Illinois Area Of Special Education

5837 Park Drive • Charleston, IL 61920
 Phone: 217-348-7700 Fax: 217-348-7640

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 _____