Tri-County Special Education Joint Agreement
Jackson, Perry & Union Counties
1725 SHOMAKER DRIVE Murphysboro, Illinois 62966
Phone: 618-684-2109 FAX: 618-687-1638 C.W. (Chuck) Hamilton, Director

AUDIOLOGICAL REFERRAL for HEARING EVALUATION ONLY

Date of Referral:_____ Referred by: _____

Student: _____ DOB: _____

School District Requesting Hearing Evaluation: _____

Teacher: _____

Parents: _____ Phone: _____

Address: _____

Hearing screening results: ☐ **Pass** ☐ **Fail** ☐ **Could Not Condition**
**Please attach copy of screening results.*

Does this child have a known hearing loss? ☐ Yes ☐ No

☐ *Annual monitoring audiometry requested*

Does this child currently receive special education services? ☐ Yes ☐ No
** If this request is part of a special education case study referral, the INA documentation and parent consent for testing replaces the use of this form*

Additional Information:_____
**If your child is currently being seen by an audiologist or being treated by an Ear, Nose and Throat (ENT) doctor who offers audiological services and has recently completed an audiogram, please provide results of the most recent evaluations or contact the person making this referral to share relevant information.*

☐ **I give consent** for audiological testing ☐ I **DO NOT** give consent

Parent Signature_____ **Date**_____

Upon parent consent,
TRI-COUNTY SPECIAL EDUCATION will process this request to the designated audiologist.
****Building/district administrative approval is required if this referral is outside the special education process.***

_____***Date***_____
*Principal Signature

_____ ***Rec***_____
Tri-County Coordinator of Audiological Services