ALLEGHENY INTERMEDIATE UNIT

Date referral received from school district: _____

Date referral emailed/mailed to educational audiologist _____

REFERRAL FOR HEARING SUPPORT SERVICES

Service(s) Requested:

- ☐ **Determination of Eligibility**
- ☐ **Audiology only (check only if you are a school district with own Teacher of the Deaf/HH)**
- ☐ **Other (please specify):** _____

IMPORTANT! PLEASE ATTACH ALL CLINICAL HEARING TEST RESULTS FOR REVIEW

(A recommendation cannot be made without a recent clinical audiogram and report provided by parent)

PLEASE DO NOT SEND A PERMISSION TO EVALUATE FORM UNTIL CONTACTED BY THE HEARING OFFICE.

Student Last Name:		**Student First Name:**	**DOB:**
Grade:	**School:**	**School Phone No:**	
District:	**Parent/Guardian:**		
Street Address: **City/State/Zip:**	**Cell #:**	**Email:**	
SS# or Student ID# (Optional):	**Home #:**	**Work #:**	
District Contact:	**Phone #:**	**Email:**	

Transfer Students only: Please attach current ER/IEP

From Within PA: ☐ Yes ☐ No

Amount of Hearing Support Services designated on IEP:_____

Place a "√" next to the services which the student currently receives.
Place an "X" next to the services for which the student is currently being evaluated.

(11)_____Academic Gifted Support
(01)_____Academic Learning Support
(02)_____Life Skills Support
(04)_____Emotional Support
(06)_____Deaf or Hard of Hearing Support
(10)_____Blind or Visually Impaired Sensory Support
(07)_____Speech & Language Support
(08)_____Physical Support
(26)_____Autistic Support
(03)_____Multi-handicapped Support

Additional Comments: _____

_____

DISTRICT LIAISON/SUPERVISOR SIGNATURE _____ Date:_____

The LEA's signature authorizes the AIU to conduct the evaluation. If this form is emailed by the LEA/designee, the email will be considered as authorization to proceed.

This form can be emailed as an attachment to DHHreferral@aiu3.net or faxed to 412-394-5783
If you have any questions, please feel free to call Ms. Milbert at 412-394-5843