Manitoba
Education
Program and Student Services Branch

Consultant for the Deaf and Hard of Hearing Referral Form

NAME: _____ (Family Name / Given Name) BIRTHDATE: _____ (Day / Month / Year) SEX: _____ GRADE: _____

ADDRESS: _____ (Postal Code) PHONE NUMBER: _____

WORK NUMBER: _____

FATHER'S NAME *(Guardian)*: _____ MOTHER'S NAME *(Guardian)*: _____

SIBLINGS *(Name, age)*: _____

LANGUAGES SPOKEN IN HOME: _____ CHILD'S COMMUNICATION METHOD *(ASL, Oral, Other)*: _____

SCHOOL: _____ SCHOOL DIVISION: _____

TEACHER: _____ PRINCIPAL: _____

RESOURCE TEACHER: _____ AUDIOLOGIST: _____

TYPE OF AMPLIFICATION: _____

OTHER MEDICAL/PHYSICAL CONDITIONS: _____

OTHER PROFESSIONALS/AGENCIES INVOLVED: _____

1) REASON FOR REFERRAL:

2) EXPLAIN LANGUAGE, SPEECH AND HEARING DIFFICULTIES OBSERVED AND UNDER WHAT CIRCUMSTANCES:

3) ACADEMIC DEVELOPMENT **(Strengths and weaknesses)**:

4) PLEASE INDICATE WHAT SPECIFIC HELP YOU WISH TO OBTAIN BY THIS REFERRAL:

5) **PLEASE INCLUDE A COPY OF THE MOST RECENT AUDIOLOGICAL ASSESSMENT.**

Signature of parent or guardian agreeing to this referral: _____ Date: _____

Signature of school personnel making referral: _____ Position: _____ Date: _____

xc: 1) School 2) Consultant for the Deaf and Hard of Hearing 3) Special Education Coordinator

Feb. 2011