Center for Deaf and Hard of Hearing Education

FOR OFFICE USE ONLY
Date Received: _____

REFERRAL FOR ASSESSMENT OR CONSULTATION

SENT VIA: ☐ **E-MAIL** [CDHHE@ISDH.IN.GOV, LOBARTLETT@ISDH.IN.GOV, DSALAZAR@ISDH.IN.GOV] ☐ **FAX** [317-550-4873]

☐ **POSTAL SERVICE** [ISDH-Center for Deaf & Hard of Hearing Education, 2 N. Meridian Street, Indianapolis, IN 46204-3021]

*****PLEASE COMPLETE ALL AREAS ON THIS FORM SO THE CENTER MAY BE ABLE TO BETTER PROCESS THIS REFERRAL*****

REFERRAL INFORMATION

Referral Date:	**Referred by:** ☐Parent/Guardian ☐LEA/TOR ☐Audiologist ☐Doctor ☐Other: _____	
Teacher of the Deaf/Hard of Hearing (TDHH):	**Teacher of Record (TOR):** *if different than Teacher of the Deaf/Hard of Hearing	
LEA/TOR/TDHH E-mail:	**LEA/TOR/TDHH Ph#**	**LEA/TOR/TDHH Fax#**

Information included with referral: ☐IEP/IFSP ☐Audiogram(s) ☐Language/Speech Eval. ☐School Eval. ☐Center Release ☐Other

Previous Services: ☐First Steps/Early Intervention ☐Private Therapy_____ ☐Other_____ ☐Other_____

☐ See attached IIEP Notice of (Re-)evaluation for reason for referral and requested areas of assessment; DUE DATE **(Timeline):** _____ *

☐No IIEP Notice of (Re-)evaluation generated.

REQUIRED-Reason for Referral (Why are you requesting services from the Center?): [be specific]

STUDENT INFORMATION

Student's Last Name:	**First Name:**	**DOB:**	**Age:**	**Gender:** ☐M ☐F **Other:** _____
School District:	**School of Legal Settlement:**	**School of Service (where child attends):**		
Does child/student have an IEP?	☐ **Yes, s/he has an IEP** Date of Last Case Conference:	☐ **No, s/he does not have an IEP** Why?		
STN#:	**Current Grade:**	**Primary (IEP) Eligibility:**	**Secondary (IEP) Eligibilities:**	
Parent/Guardian Names:				
Street Address:	**City:**	**County:**	**ZIP:**	
Parent/Guardian Home or Cell Phone#: Preferred Contact: ☐YES ☐NO	**Alternate Contact (Name and Phone #/Email):** Family Member? ☐ YES ☐NO	**Parent/Guardian E-mail:** Preferred Contact: ☐YES ☐NO		
Home Language: ☐ English ☐ASL ☐Spanish ☐Other: _____	**Student's Language:** ☐English ☐ASL ☐ Spanish ☐Other: _____			
SPECIAL CONSIDERATIONS FOR THE ASSESSMENT TEAM:				

Was/Is your child a part of an IU/Kronenberger Research Project? ☐ NO ☐ YES; Dates of Evaluation(s):_____

Indiana State Board of Education Special Education Rules, Article 7 www.in.gov/legislative/iac/T05110/A00070.PDF
511 IAC 7-32-60 LEA: **L**ocal **E**ducation **A**gency includes school corporations, charter schools, state-operated schools

*Allow 6-8 weeks for report completion from the confirmed date of assessment, unless there is another agreed upon and documented due date. Assessment dates are set approximately 3-6 months from receipt of all referral paperwork (Center Referral form as well as the student's educational, medical, and audiology records) for the Center Assessment Team to review and plan for the requested evaluation.