



Area Special Education Cooperative

1505 Central Ave NW, East Grand Forks, MN 56721
218/773-0315 FAX: 218/773-0924

AUDIOLOGICAL REFERRAL FORM

Date _____

Parents' Name _____

Student _____

Case Manager _____

Birthdate _____

School _____

Referral Information

Hearing: Date screened _____

Is this a new referral?

Yes

No

Does the child have a documented hearing loss?

Yes

No

Hearing: Date tested _____

Classroom Performance Information

What information do you want from the audiologist?

Audiological

Tympanometry

SRT

Clinical Impression

Consulting Audiologists (suggested): Please check preference

Dr. Kevin Fire
Clinical Audiologist
921 Reeves Drive
Grand Forks, ND 58201
(701) 787-5862

Other: _____

Scheduled Appointment Date: _____

_____ Approved _____ Disapproved

Director's Signature

Date

After ASEC approval, a copy of this form will be sent back to the person making the request. Send the audiologist a copy of this form. Fees will be paid upon receipt of a written report from the audiologist. Bill to: ASEC, 1505 Central Avenue NW, East Grand Forks, MN 56721.