TOOLS for SCHOOLS™

COCHLEAR IMPLANT Audiology Referral Form

Student Name: ______________________ Date: __________

Requested By: ______________________

Educator Phone Number or Email: ______________________

Reason for referral
(Check all that apply and provide specific examples or details)

- ☐ Equipment problem: ______________________
- ☐ Changes in sound awareness: ______________________
- ☐ Changes in classroom or therapy behavior: ______________________
- ☐ Changes in speech recognition: ______________________
- ☐ Changes in speech production: ______________________
- ☐ Changes in processor settings: ______________________
  (Indicate current user settings)
- ☐ Other: ______________________

Advanced Bionics

For questions or additional information:

Toll Free Phone: 1-877-829-0026
TTY: 1-800-678-3575
Monday Through Friday, 5am to 5pm PST

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027-M604-03
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