

Educator's Cochlear Implant Evaluation Ear & Hearing Center Cincinnati Children's Hospital Medical Center

**This form <u>must</u> be completed by your child's teacher/speech therapist or Early Interventionist/Help Me Grow/Regional Infant Hearing Program representative **

Child's Name	DOB		
School/Program Name			
Form completed by:	Date:		
Is your school program Oral T	TC Manual (circle one)		
1. Does the child wear a: HA What type/brand?	FM Both (circle one)		
2. Describe the child's usage of amplification at school and at home			
Describe the child's main mode of communication Describe the child's auditory progress with the current amplification			
5. Describe any physical or cognitiv	ve disabilities impacting the child's progress		
6. What support services are offered to this child at your school/by your program?			
7. Describe the child's speech and I	language abilities (date of recent IEP/MFE)		
8. Describe the child's attendance h	history and parental involvement		
9. Describe your impression of the child's and family's expectations of the cochlear implant			

School Name		- <u></u>
School Address		
School Phone _		
Name and Title		
Phone Number _		
Email Address _		
3	nt receive a cochlear implant, w the devices and troubleshooting	3
	copies of this form to giv working with this stude	
Additional commer	nts regarding this student and th	he cochlear evaluation process:

Please provide us with the following information so that we may keep you informed of the child's progress in the cochlear implant evaluation process.

Please mail or fax to: Christine Eby Fishman, AuD, FAAA Operations Coordinator, Cochlear Implant Team 3333 Burnet Avenue, ML 2002 Cincinnati, OH 45229 Fax (513) 636-7316