

Educator's Cochlear Implant Evaluation

Ear & Hearing Center

Cincinnati Children's Hospital Medical Center

***This form **must** be completed by your child's teacher or
EI/HMG/RIHP representative*

Child's Name _____ DOB _____

School/Program Name _____

Form completed by: _____ Date: _____

Is your school program **Oral** **TC** **Manual** (circle one)

1. Does the child wear a: **HA** **FM** **Both** (circle one)

What type/brand? _____

2. Describe the child's usage of amplification at school and at home _____

3. Describe the child's main mode of communication _____

4. Describe the child's auditory progress with the current amplification _____

5. Describe any physical or cognitive 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 language abilities (date of recent IEP/MFE)

8. Describe the child's attendance history and parental involvement _____

9. Describe your impression of the child's and family's expectations of the
cochlear implant _____

