



Cochlear Implant (CI) Referral Form
Division of Audiology
(513) 636-4236
(513) 636-7316--fax

Check one: [] Obtaining information

Interested in CI evaluation for:

- [] Unilateral
[] Simultaneous Bilateral
[] Sequential Bilateral

Patient's Name: _____ DOB: _____ MR# _____

Parents: _____ Phone # _____

Address: _____ Are parents able to read? YES NO

Degree of Loss: _____ Date Dx'd: _____

Etiology: _____ If Meningitis, when?: _____

Child's Other Handicaps: _____

Amplification Used/Length of Time Used: _____

Primary Mode of Communication: _____ Sign interpreter needed: YES NO

Primary language spoken at home: _____ Interpreter needed: YES NO

Level of Parent/Patient Interest: [] Very [] Somewhat [] Not interested

Comments: _____

ENT: _____ Pediatrician: _____

Grade/School Attended: _____ Interpreter? YES NO

Type of Classroom: Hearing-impaired classroom Resource room Mainstreamed

Enrolled in Speech Therapy? YES NO Where/with whom? _____

Enrolled in Aural Rehab? YES NO Where/with whom? _____

PLEASE ATTACH MOST RECENT AUDIOGRAM

RETURN TO LISA HILBERT ML2002

Referred by: _____ Date: _____

Date Received: _____ By: _____

Entered in Database: [] By: _____