



Cochlear Implant Team
Cochlear Implant School & Intervention Form
Page 1 of 3

Name: _____
DOB: _____
MRN: _____

*Please make copies of this form to give to other professionals working with the child at your facility.
Please provide all written reports that include observations of auditory abilities and speech language test results.*

Date: _____

Name of person completing form: _____ Title: _____

Phone number: _____ Email address: _____

Program name: _____

Program address: _____

Describe the child's main mode of communication: _____

Is your school program? (Check all that apply) Oral Total Communication Manual (sign) Mainstream

What support services are offered to this child at your school or by your program? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Educational audiologist | <input type="checkbox"/> Interpreter |
| <input type="checkbox"/> Classroom aide | <input type="checkbox"/> Speech therapy |
| <input type="checkbox"/> Hearing itinerate teacher | <input type="checkbox"/> Special education |
| <input type="checkbox"/> Other: _____ | |

What accommodations are there for hearing loss? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Preferential seating | <input type="checkbox"/> Extended test time |
| <input type="checkbox"/> Captioning | <input type="checkbox"/> Note taker |
| <input type="checkbox"/> Modified assignments | <input type="checkbox"/> Resource room |
| <input type="checkbox"/> Pre-teaching | |

Does the child wear any of the following? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> FM system/remote microphone |
| <input type="checkbox"/> Cochlear Implant (CI) | <input type="checkbox"/> N/A |

Describe the child's auditory progress with the current amplification: _____

How much difference do you see when this child is wearing versus not wearing hearing devices?

- Very little difference Some difference Quite a difference

Does the child wear hearing devices consistently and without resistance during school/therapy? Yes No

If **NO**, please describe: _____

If this child **does not** recognize speech do they recognize speech patterns songs and phrases? Yes No N/A





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Page 2 of 3

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How would you characterize this child's auditory learning style?

- Learns easily through casual listening
- Repetition and visual cues really help
- Dependent on visual cues and routine, to learn

Please select this child's ability to learn vocabulary:

- Rapidly learns new words through overhearing
- Needs to hear new words more often than others
- Poor, every word requires direct instruction

How does this child communicate with peers (i.e., speech, sign language, gestures)?

This section is to be completed by the Speech Language Pathologist:

(Please enclose a copy of the IFSP, IEP / Multi-Factored Evaluation (MFE) and any additional speech and language test results)

Describe the child's speech and language abilities: _____

How many words does the child... Speak: _____ Sign: _____

How many words does the child understand? Spoken: _____ Sign: _____

What tests have been completed? *(Check all that apply)*

Birth-3:

- Rossetti Infant Toddler Language
- MacArthur Bates Communicative Development Inventories (Words and Gestures or Words and Sentences)

Preschool:

- Clinical Evaluation of Language Fundamentals – Preschool- age 2
- Goldman Fristoe Test of Articulation – 3

School age:

- Clinical Evaluation of Language Fundamentals – 5
- Goldman Fristoe Test of Articulation – 3

Describe any physical or cognitive disabilities impacting the child's progress: _____

Describe the child's attendance history: _____

Describe the parent's involvement: _____



Cochlear Implant Team
Cochlear Implant School & Intervention Form
Page 3 of 3

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

Additional comments regarding the child and the cochlear evaluation process: _____

Signature of Person Completing Form

Printed Name

Date

Please return all documents by ONE of the following ways:

- **FAX:** 513-636-7316
- **Email:** AuditoryImplantProgram@cchmc.org
- **Mail:**
Cincinnati Children's Hospital Medical Center
Audiology/ ML 2002
Attn: Auditory Implant Program Coordinator
3333 Burnet Ave, Cincinnati, OH 45229

If you have any questions regarding this form, please contact the Auditory Implant Coordinator by calling 513-636-4236.