Child's Name: _____
DOB: _____
MRN: _____

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

School/Program name: _____

Is your school program? (Check one) ☐ Oral ☐ Total Communication (TC) ☐ Manual

1. Does the child wear a: (check one) ☐ Hearing Aid (HA) ☐ FM system ☐ Both
   What type/brand? _____
2. Describe the child's amplification use within the setting that you see the child: _____
   _____
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 or by your program? _____
   _____
7. Describe the child's speech and language abilities (please enclose a copy of the IFSP, IEP / Multi-Factored Evaluation (MFE)): _____
   _____
8. Describe the child's attendance history: _____
   _____
9. Describe the parent's involvement: _____
   _____
10. Describe your impression of the child's and family's expectations of the cochlear implant: _____
    _____
    _____

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.

Name: _____ Title: _____

Phone Number: _____

Email address: _____

School Name: _____

School Address: _____

School Phone: _____

Should the child receive a cochlear implant, would you be interested in training regarding the devices and troubleshooting? ☐ Yes ☐ No

Child's Name: _____

DOB: _____

MRN: _____

Please make copies of this form to give to other professionals working with the child at your facility.

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

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Person Completing Form Print Name Date

Please mail or fax to:
Cochlear Implant Program Coordinator
Children's Hospital Medical Center
3333 Burnet Ave. ML 2002
Cincinnati, OH 45229
Fax: 513-636-7316
Phone: 513-636-4236