EDUCATIONAL SERVICES UNIT

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Burlington County Special Services School District
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Educational Audiology
Service Request Form

Student Information		**District Information**	
Student's Name:		**School District:**	
NJ SID #:		**Contact Person:**	
Classification:		**Phone Number:**	( )
DOB:		**FAX Number:**	( )
School Attending:		**Email Address:**	
Grade:		**Case Manager:**	

Assessments & Therapy

☐ **Audiological Evaluation:** *Student evaluation of hearing acuity using audiometry (air and bone) and otoscopy and report (1 hour)*

☐ **Auditory Processing Evaluation:** *Includes a full battery of tests to evaluate for APD and report (minimum of 2 hours)*

☐ **Auditory Training/Listening Therapy:** ***(1 hour minimum)*** **Frequency: ____ hours per week**
Direct services to build listening pathways or improve listening skills in challenging listening school environments

As Needed Services

☐ **Acoustic Check/Modification Recommendations: (Select one – either Quick Check or Evaluation)**

☐ **Classroom Quick Check:** *Class sound level meter reading to determine background noise, observe the environment and report.*

☐ **Number of classrooms: ____ List room #'s: _____** *(Billed 1.5 hour per room)*

☐ **Acoustic Evaluation:** *Evaluation of background noise, unoccupied and occupied rooms/settings, reverberation time, multiple sound level meter readings and report on outcomes and recommended classroom modifications*

☐ **Student Specific classroom(s): Number of classrooms____ Room #(s): _____** *(Billed 2.5 hours per room including the report)*

☐ **Schoolwide (*not student specific*) 8 hour minimum**

☐ **Hearing Assistive Technology (HAT) Recommendations:** *(1 hour minimum)*
Recommendations will be made as to what type of HAT (such as, FM system or soundfield system) would be the most appropriate taking into consideration the current type of amplification and other classroom or school-wide technology with which the HAT might interfere

☐ **School Year HAT/Personal Amplification Maintenance/Troubleshooting: _____# hours per year**
Services include any of the following: in person, via phone, video conferencing, email, "on call. Note: hours do not include IEP meeting attendance

☐ **IEP Meeting attendance: Date/Time: _____ Location: _____**

☐ **Workshop(s):** *Catered to your school nurses, teachers and/or staff working with student with hearing loss. (Prep time of .5 added to each hour)*
Topics include tips for school hearing screenings, classroom listening environment, hearing assistive technology - what it is and how to use it, etc.
Topic: _____ Length of Workshop: ___ hours Date/Time: _____

Signature and date below indicate approval of services requested

_____ _____
CST Director Signature **Date**

Please fax the completed form to: 609-534-2066 or email to ESUDHH@burlcoschools.org. Questions please call: 609-702-0500 x7401

Note: Out of county school districts requesting services will incur destination charges to/from service locations outside of Burlington County.
District Case Manager will be contacted by the D/HH Department upon receipt of the form to confirm the request for services.
Where not indicated, the Educational Audiology PSA rate will be applied for the amount of hours to complete the service