Date: _____

MAIL TO:

Northeast Regional Deaf and Hard of Hearing
Box 139
Norfolk, NE 68702
FAX: (402) 644-2506

HEARING REFERRAL

_____ Name of Student Being Referred

_____ Date of Birth

_____ Name of Parents

_____ Home Address

_____ Home Telephone

_____ School Student Attends

_____ _____ School District and Address

_____ School District Phone #

The above named student is being referred for audiological testing through the Northeast Nebraska Program for Children who are Deaf or Hard of Hearing with Vernae Luhr, M.A., CCC-A.

*The School district assumes the cost for this testing. The bill for such services and a copy of the test results are to be sent to the administrator listed below.

Also, please send a copy of test results to the person making the referral at the school address directly below.

_____ _____
(Signature of Staff Member Making Referral) (Title)

_____ _____
(School Address of Referring Staff Member) (Contact Phone #)

Approved by School Administrator

_____ _____
(**Printed** Name of School Administrator) (**Signature** of School Administrator

Comments: