School Year 2020-2021

Please be patient after submitting the form as it may take time to process. You will receive a notice that an email has been sent.

# Student Hearing Aid/Cochlear Implant Info – Beginning of Year

**Student Last Name:** **First Name:**

**Current audiologist name:**

**Current audiologist address:**

**If your child's hearing loss is managed by a non-USM audiologist, do you want to continue with the current services or change to USM?**

◯ **Change to USM** ◯ **Keep Current Services**

**Hearing Loss:**

**A.** ◯ **Left** ◯ **Right** ◯ **Binaural**

**B.** ◯ **Congenital? (from birth)** ◯ **Acquired?**

**Notes:**

1. **Type of amplification used:**
   - ☐ **Hearing aid – right ear**
   - ☐ **Hearing aid – left ear**
   - ☐ **Hearing aids – binaural**
   - ☐ **Cochlear implant – right ear**
   - ☐ **Cochlear implant – left ear**
   - ☐ **Cochlear implants – binaural**
2. **Brand name of aid(s) or implant(s)**
3. **Serial number(s) of aid(s) or implant(s)**
4. **Student's age at initial amplification:**
5. **If implant, age when implanted:**
6. **If implant, were aids used previously:** ◯ **Yes** ◯ **No** ◯ **N/A**
7. **Consistent use of amplification previously?** ◯ **Yes** ◯ **No**
8. **Consistent use of amplification currently?** ◯ **Yes** ◯ **No**
9. **Is your child Medicaid-eligible?** ◯ **Yes (Please provide copy of card.)** ◯ **No**

**Additional Information:**

**Rev. 7/17/19**