**Assistive Technology**

**Referral for Sound Field/Personal FM Systems**

If this request is for replacement of a Sound Field System or Personal FM Sytem, please complete the Assistive Technology Device Evergreening Checklist for Students with Hearing Loss instead of this form.

Student’s Name:

This referral is for: [ ]  Sound Field System [ ]  Personal FM System

**For requests for Soundfield Systems,** please specify:

Manufacturer:       Make:       Model:

**For requests for Personal FM Systems** please specify:

 Receiver(s) requested

Manufacturer:       Make:       Model:       Number Required:

Transmitter(s) requested

Manufacturer:       Make:       Model:       Number Required:

Amplification for which student has been fitted:

[ ]  Implants Specific version:

[ ]  Hearing Aids Specific version:

Are audio shoes required? [ ]  Yes [ ]  No

If yes, type of audio required:       Number required:

I certify that:

[ ]  This student meets the criteria of Hearing Loss

[ ]  This student is on my current DHH caseload

[ ]  An evaluation of the student’s classroom environment has determined that this assistive technology (AT) would be a valuable support to the student’s learning

[ ]  The information provided above is an accurate assessment of need

[ ]  The use of this AT is recommended by this student’s program planning team

|  |  |  |
| --- | --- | --- |
|  |       |       |

Signature of DHH Teacher completing this form Please type/print name Date

**Please attach this form to student's AT Application.**