**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

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

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