

**COCHLEAR IMPLANT EVALUATION REQUEST FORM**

To be completed by referring audiologist or physician

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Please indicate age of child and degree of hearing loss	<18 MONTHS	18 MONTHS to 36 MONTHS	>3 YEARS OLD
AGE _____  Pure Tone Average (if available, of 500 Hz, 1K Hz, 2K Hz, AND 4K Hz)	Qualifying: Bilateral profound (>90 dB nHL) SNHL  RE: _____ LE: _____	Qualifying: Bilateral Severe-profound (>70 dB HL) SNHL  RE: _____ LE: _____	Qualifying: Sloping Bilateral Moderate-profound SNHL (Moderate loss in low frequencies only, with severe-profound loss 1000 Hz – 8000 Hz)  RE: _____ LE: _____  IF PTA is less than 70 dB, please indicate speech discrimination scores (must be below 60% for consideration)  RE: _____ LE: _____

Etiology of hearing loss (if known): \_\_\_\_\_ Age of diagnosis: \_\_\_\_\_

**Please answer the following questions**

- Y  N Does the child wear hearing aids? Make/Model \_\_\_\_\_ Date fit \_\_\_\_\_
- Y  N Does the child cooperate during visits?
- Y  N Are the caregivers compliant with appointments/recommendations?
- Y  N Does the child exhibit communicative intent? \_\_\_\_\_
- Y  N Is the child receiving educational services? Type: \_\_\_\_\_
- Y  N Does the child communicate with signs? \_\_\_\_\_
- Y  N Does the child attempt oral communication?
- Y  N Has the child been evaluated at another Cochlear Implant Center? Where? \_\_\_\_\_
- Y  N Do the caregivers use the same method of communication as the child? \_\_\_\_\_
- Y  N Has the method of communication been demonstrated by the parents in your office?
- Y  N Has there been a period of auditory deprivation? How long? \_\_\_\_\_
- Y  N Are the caregivers aware that cochlear implantation is a surgery? \_\_\_\_\_
- Y  N Are the caregivers aware that cochlear implantation is NOT a cure for hearing loss?
- Y  N Are the caregivers aware of the multiple appointments necessary before AND after cochlear implantation?
- Y  N Are the parents informed of ALL options available to hearing impaired children?
- Y  N DOES THE CHILD MEET BASIC AUDIOMETRIC CRITERIA AS LISTED IN CURRENT CCS POLICY?

Audiology Provider: \_\_\_\_\_ Facility: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

**How has the family and/or candidate demonstrated motivation to commit to a long-term rehabilitation program?**

**What are the parents/caregivers/candidate's expectations regarding cochlear implantation?**

**Where is the child receiving educational services and/or rehabilitation services? Please list specific names and programs.**

**Additional comments and clarification:**

**PLEASE NOTE: Recommendation for a cochlear implant evaluation does not assure that an evaluation will occur. Each Cochlear Implant Center triages the individual case according to their own cochlear implant fitting criteria. The Cochlear Implant Center will determine whether the patient is an appropriate candidate for that center's program. PLEASE INFORM YOUR PATIENT.**

\_\_\_\_\_  
Signature of Audiologist

\_\_\_\_\_  
Date

Please enclose:

- Reports of audiological evaluations, including most current audiogram or evoked potential report (must be within last 6 months)
- Hearing aid data and reports, to include aided audiogram (if available)
- Related evaluations (speech/language, speech perception, psycho/social, radiographic)