

### COCHLEAR IMPLANT EVALUATION REQUEST FORM

To be completed by referring audiologist or physician

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

Type and degree of hearing loss (please enclose audiogram): \_\_\_\_\_

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

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)

#### Please answer the following questions

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|---|---|---|
| Y | N | Does the child wear hearing aids?<br>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?<br>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?<br>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?<br>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 HAVE A BILATERAL MODERATE SLOPING TO SEVERE-PROFOUND SENSORINEURAL HEARING LOSS?         |
| Y | N | ARE YOU RECOMMENDING AN EVALUATION FOR A COCHLEAR IMPLANT?  |

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?**

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

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

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**Additional comments and clarification:**

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**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

To be completed by CCS office:

CCS number \_\_\_\_\_ County \_\_\_\_\_ Date of SAR \_\_\_\_\_

- Current report and/or audiogram     SAR request  
 Additional relevant reports, if available (ENT, SLP, school)

PHN \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

**COCHLEAR IMPLANT TEAM EVALUATION RESULTS and SURGICAL REQUEST FORM**

To be completed by a member of the Cochlear Implant Evaluation Team

Please include relevant cochlear implant evaluation reports

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

CI CENTER \_\_\_\_\_ PHONE \_\_\_\_\_

TEAM MEMBER COMPLETING FORM \_\_\_\_\_

You are requesting (Please check one):  Unilateral Implant  Bilateral Implants

<b><u>TEAM MEMBER CHECKLISTS</u></b>	<b><u>COMMENTS:</u></b>	<b><u>RECOMMEND IMPLANT?</u></b>
<b><u>MEDICAL:</u></b> <ul style="list-style-type: none"> <li>○ Diagnosis of Meningitis</li> <li>○ Free from middle ear infection</li> <li>○ Accessible cochlear lumen &amp; viable cochlear nerve</li> <li>○ No lesions in acoustic area of central nervous system</li> <li>○ No contraindications to surgery</li> </ul>		YES  NO
<b><u>AUDIOLOGICAL:</u></b> <ul style="list-style-type: none"> <li>○ Audiometric criteria, bilateral moderate sloping to severe-profound loss</li> <li>○ Speech perception testing</li> <li>○ Appropriately fitted hearing aid trial</li> <li>○ Minimal periods of auditory deprivation</li> </ul>		YES  NO
<b><u>SPEECH/LANGUAGE:</u></b> <ul style="list-style-type: none"> <li>○ Joint attention, communicative intent, language base</li> <li>○ Speech/language evaluation</li> <li>○ Parents/caregivers using appropriate communication method</li> </ul>		YES  NO
<b><u>PSYCHO-SOCIAL:</u></b> <ul style="list-style-type: none"> <li>○ Appropriate expectations regarding prognosis of implant</li> <li>○ Demonstrated motivation by parents or caregivers</li> <li>○ History of compliance to medical evaluations and treatments</li> <li>○ Behavioral and developmental indications that would not interfere with rehabilitation</li> </ul>		YES  NO
<b><u>EDUCATIONAL:</u></b> <ul style="list-style-type: none"> <li>○ Willingness to enroll in most appropriate educational setting, as recommended by CI Team</li> <li>○ Review of IFSP or IEP</li> </ul>		YES  NO
<b><u>OVERALL RECOMMENDATION OF CI TEAM</u></b>		

To be completed by CCS office:

CCS number \_\_\_\_\_ County \_\_\_\_\_ Date of request \_\_\_\_\_

PHN \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_