Health Services

Nurse Referral Form
HEARING

Referral Date _____

Student's Name _____ DOB _____

Grade/Teacher _____ School _____

Hearing assessment at school leads us to believe that this student needs an evaluation of hearing. Screening showed a possible loss.

	1000Hz	2000Hz	4000Hz
Right Ear			
Left Ear			

We advise that you consult your Health Care Provider or a Specialist. This suggestion is offered in the interest of this student's health and progress in school.

For further advice, you may confer with the school nurse.

School Nurse:_____ Telephone No.:_____

PLEASE TAKE THIS FORM T0 YOUR HEALTH CARE PROVIDER.

HEALTH CARE PROVIDER'S REPORT

Date _____

Student's Name _____

Health Care Provider's Remarks _____

_____

_____

_____

_____

Signature _____ Date _____

Print HCP Name _____

Please return this form to the school for inclusion in the student's health record as soon as evaluation is made.