Attachment 1

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

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 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

TEAM MEMBER CHECKLISTS	**COMMENTS:**	**RECOMMEND IMPLANT?**
MEDICAL: ○ Diagnosis of Meningitis ○ Free from middle ear infection ○ Accessible cochlear lumen & viable cochlear nerve ○ No lesions in acoustic area of central nervous system ○ No contraindications to surgery		YES NO
AUDIOLOGICAL: ○ Audiometric criteria, bilateral moderate sloping to severe-profound loss ○ Speech perception testing ○ Appropriately fitted hearing aid trial ○ Minimal periods of auditory deprivation		YES NO
SPEECH/LANGUAGE: ○ Joint attention, communicative intent, language base ○ Speech/language evaluation ○ Parents/caregivers using appropriate communication method		YES NO
PSYCHO-SOCIAL: ○ Appropriate expectations regarding prognosis of implant ○ Demonstrated motivation by parents or caregivers ○ History of compliance to medical evaluations and treatments ○ Behavioral and developmental indications that would not interfere with rehabilitation		YES NO
EDUCATIONAL: ○ Willingness to enroll in most appropriate educational setting, as recommended by CI Team ○ Review of IFSP or IEP		YES NO
OVERALL RECOMMENDATION OF CI TEAM		

To be completed by CCS office:
CCS number ________________County_________________Date of request ________

PHN______________________________Phone_____________E-mail______________