Appendix-Section 1

INSPIRE • EQUIP • IMAGINE

FBISD
INSPIRE • EQUIP • IMAGINE

*DATE OF EVALUATION _____

BRAZORIA-FORT BEND REGIONAL DAY SCHOOL PROGRAM FOR THE DEAF

☐ Initial Assessment
☐ Reevaluation
☐ Special Request by ARD/IEP Committee

COMPREHENSIVE INDIVIDUAL ASSESSMENT

Eligibility Report: Deaf/Hard of Hearing
Audiological Evaluation

NAME: _____ DOB: _____

PROFESSIONAL EVALUATOR: Licensed Audiologist

*RESULTS (Attach audiogram and other results available)

Otoscopic Examination: Immittance Testing:

***UNAIDED TESTING:**

Puretones(dBHL):	250	500	1000	2000	3000	4000	6000	8000Hz
Right								
Left, or								
Soundfield								

Speech: ☐ SDT ☐ SRT Right _____ Left _____ Soundfield _____

Word Discrimination (Quiet): Stimulus _____ Presentation Level _____

Right _____ Left _____ Soundfield _____

ADDITIONAL TEST RESULTS:

Auditory Brainstem Response (ABR) _____

Other, please specify _____

Type and severity of the hearing loss: _____

☐ YES ☐ NO Need for amplification (***if YES, complete the AMPLIFICATION section, p.2**)

***AIDED TESTING:**

Puretones(dBHL):	250	500	1000	2000	3000	4000	6000Hz
Binaural, or							
Right							
Left							

Speech: ☐ SDT ☐ SRT Right _____ Left _____ Binaural _____

Word Discrimination (Quiet): Stimulus _____ Presentation Level _____

Right _____ Left _____ Binaural _____

Word Discrimination (Noise): Stimulus _____ Presentation Level _____ S/N Ratio _____

Right _____ Left _____ Binaural _____

*Denotes required items

Child's Name: _____ DOB: _____ Date of Evaluation: _____

***LISTENING TECHNOLOGY**

	HEARING AID(S)/COCHLEAR IMPLANT(S)			FM SYSTEM	
	RIGHT	LEFT		RIGHT	LEFT
Make					
Model					
Serial					
Type					
Receiver					
Vol. Setting					
Ext. Setting					
Int. Settings					

Electroacoustic analysis of amplification:

☐ YES ☐ NO Hearing aid(s) meet(s) manufacturer's specification for gain, output, and distortion.

Hearing aid benefit/ program settings verified using the following method(s):

_____ Aided soundfield testing Date:_____

_____ Real Ear Measures (REM) Date:_____

(or Simulated REM)

***Implications:** With and without listening device, this child **may** be expected to:

With **Without**

____ _____ have no difficulty hearing in most listening environments.

____ _____ have some difficulty hearing and/or understanding speech in difficult listening environments.

____ _____ have some sound awareness; likely to have significant difficulty understanding speech in most listening environments.

____ _____ hear and understand little to no speech in any environment without visual cues.

____ _____ have difficulty localizing sounds.

____ Other_____

Recommendations in the classroom setting:

____ Consistent use of listening technology(s)

____ Preferential seating

____ Use of an Assistive Listening Device (ALD)/Hearing Assistive Technology (HAT)

____ Educational Audiologist should evaluate this child to determine appropriate classroom placement and modifications

____ Other_____

*Hearing aid(s) programmed for use with: ____neckloop ____boots/DAI ____ ALD only ____ FM + Mic___

Other: _____

ALD/HAT/FM program is in program #_____ Access this program by: _____

_____ _____

***Signature of Licensed Audiologist** **Date of this Report**

_____ _____

Name (Please Print) Audiologist's Telephone Number

***Denotes required items**

DATE OF EVALUATION

_____

BRAZORIA-FORT BEND
REGIONAL DAY SCHOOL PROGRAM
FOR THE DEAF

☐ **Initial Assessment**
☐ **Reevaluation**
☐ **Special Request**
by ARD/IEP Committee

COMPREHENSIVE INDIVIDUAL ASSESSMENT

Eligibility Report: Deaf/Hard of Hearing
Otological Examination

NAME: _____ **DOB:**_____

PROFESSIONAL EVALUATOR: Otologist or other licensed physician (if Otologist is not available)

ENT EXAMINATION:
Physical Findings:

Pathology
Otitis Media (Acute) R _____ L ____ B____
Otitis Media (Chronic) R ____ L____ B ____
Other, specify:_____ _____

***Type of impairment:**

Hearing loss
None R ____ L____ B____
Conductive R ____L____ B____
Sensori-Neural R____L____ B____
Mixed R____ L____ B____

Are there any structural anomalies of the ear, nose, or throat?
Ear _____ Nose _____ Throat _____

☐ YES ☐ NO ***Is medical treatment recommended?**
For what condition? _____

***Severity of hearing loss:**

Normal limits (0-20dB)	R _____ L _____ B _____
Mild hearing loss (20-30dB)	R _____ L _____ B _____
Moderate hearing loss (30-50dB) Moderately-	R _____ L _____ B _____
severe hearing loss (50-70dB) Severe hearing	R _____ L _____ B _____
loss (70-90dB)	R _____ L _____ B _____
Profound hearing loss (over 90dB)	R _____ L _____ B _____

***Severity of hearing loss is based upon:**
☐YES ☐NO Puretone Audiometry Date: _____ ☐ ABR Date: _____
Other, specify: _____

☐YES ☐NO ***Do you recommend this student be fitted with a hearing aid?**

***SIGNATURE OF OTOLOGIST OR OTHER LICENSED PHYSICIAN**

_____

ADDRESS

_____

***NAME (PLEASE PRINT)**

_____

TELEPHONE NUMBER

_____

Return completed form to: _____ at: _____
NAME ADDRESS

***Denotes required items**

AMPLIFICATION MONITORING RECORD

Month & Year: ________________

Student Name: __________________________ **CI/Hearing Aid:** __________________

Campus: __________________ **ALD:** ____________________

Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No

Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No

Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No
Date	CI/Hearing Aid		ALD	
	Right	Left	Right	Left
	Yes / No	Yes / No	Yes / No	Yes / No

Remember: Daily Ling Sound Checks: ooo/ah/eee/mmm/sss/sh

*Write additional comments on the back of this form.

AMPLIFICATION MONITORING RECORD

Date	Problem/Comment		Date	Problem/Comment

This Amplification Record should be completed daily by:

- **Student (when appropriate)**
- **Special Education Teacher**
- **Regular Education Teacher**
- **Speech Therapist**
- **Nurse, or**
- **Any other designee**

This record will serve as documentation of the student's use of the amplification as indicated on the Individual Education Plan (IEP), Special Education modification page, or by the 504 Committee. Therefore, keeping this documentation is not optional.

At the end of the year, please file this Amplification Monitoring Record in the teacher's folder.

Thank you for your cooperation.

_____

AMPLIFICATION MONITORING RECORD

Student: _____ **School Year:**

Campus: _____ **Grade:** ____

Amplification used by the student:

- ❑ **Hearing Aid(s)** **Right Ear** **Left Ear**
  - ❑ **Traditional**
  - ❑ **Digital**
- ❑ **Cochlear Implant:** **Right Ear** **Left Ear**
- ❑ **Assistive Listening Device**
  - ❑ **FM** **Right Ear** **Left Ear**
  - ❑ **Auditory Trainer:** **Right Ear** **Left Ear**
  - ❑ **Toteable** **Right Ear** **Left Ear**
  - ❑ **Other** _____ **Right Ear** **Left Ear**

Person responsible for monitoring maintaining this monitoring record:

- ❑ **Classroom Teacher**
- ❑ **School Nurse**
- ❑ **Special Education Teacher**
- ❑ **Speech Pathologist**
- ❑ **Other:** _____

Assistive Technology Parent Questionnaire

Date: _____

Student Name: _____ email: _____

Address: _____ phone number: _____

City _____ State _____ Zip Code _____ Age of child: _____

The need for assistive technology is based on the student's strengths, weakness, and the environments in which he/she works, and the instructional/curricular expectations outlined in the IEP. Please assist us in this evaluation by completing this form.

Please check any routine activities your child participates in outside the school setting:
☐Private PT ☐Private OT ☐Private Speech ☐Other therapies
If checked, may we contact the provider for additional information? ☐Yes ☐ No

If yes, please provide contact information: _____

Other Activities:
What items or activities does your child like?

Based on the instructional program outlined in your child's IEP, what does your child need to be able to do that he/she is having difficulty with now? What are your concerns?

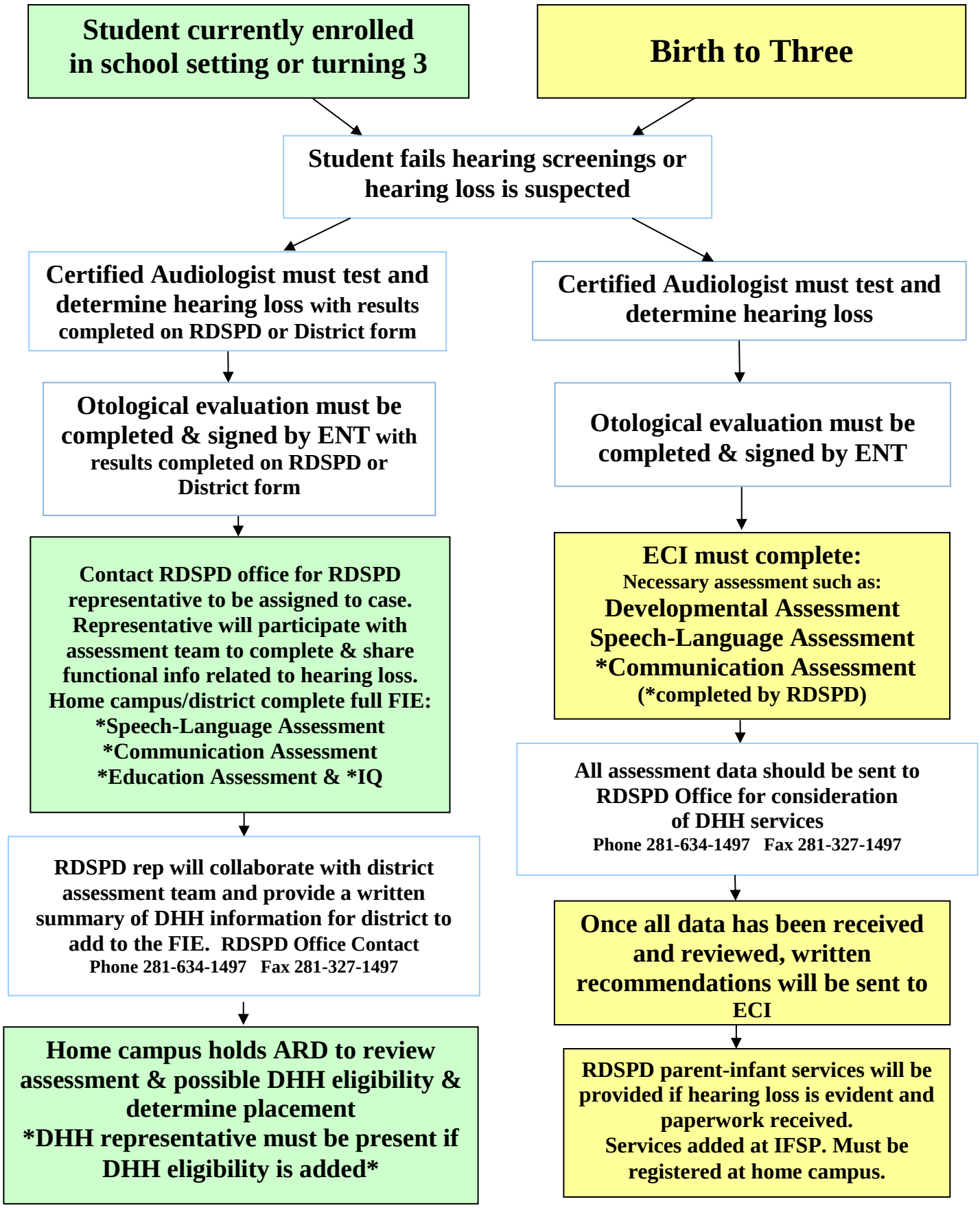
What are the barriers/specific needs related to your concerns?

What are your child's current abilities/strengths related to your concerns?

What are your short-term and/or long-term goals for your child?

Please add any additional information about your child that might assist the evaluation team during this assistive technology evaluation. (I.e. behavioral support strategies used at home, pertinent family information, etc.)

Brazoria-Fort Bend Regional Day School Program for the Deaf
***FLOWCHART FOR REFERRAL OF STUDENTS FOR DEAF/HARD OF HEARING ELIGIBILITY/ECI SERVICES**



Date: _____

Fort Bend ISD: Referral for Full and Individual Evaluation

Student Name: _____ ID#:_____ Grade: _____
Campus: _____ Teacher(s):_____
Schedule: *Lunch*: _____ *Recess*: _____ *Ancillary*: _____
**Fill in the schedule above or attach a copy of campus schedule*

Student referred by: □ RTI committee □ 504 committee □ Parent

Must include the following with this referral*:*
□ Passed Vision/Hearing Screening
□ Home Language Survey
□ Outside Reports (if applicable)

Academics: *what type of academic problem(s) does this student have?*
□ Reading - Fluency: _____
□ Reading - Phonics/Decoding: _____
□ Reading - Comprehension: _____
□ Math – Problem- Solving: _____
□ Math - Calculation: _____
□ Writing: _____

Speech Concerns*:* Yes/No
□ Articulation: _____
□ Language: _____
□ Pragmatics: _____
□ Fluency: _____
□ Voice/Other:_____

Behavior: *What type of behavior problem(s) does this student have?*
□ Aggression: _____
_____
□ Anxiety/Depression: _____
_____
□ Social Skills: _____
_____
□ Outside Diagnoses: _____
□ Other: _____
_____

Other:
□ DHH: audiogram & ENT report: _____ □ VI: Texas State Eye Report: _____
□ Orthopedic Impairment (OI)/Other Medical: _____
□ OT/PT: _____
□ Assistive Technology: _____

****Please include any other supporting documents that are readily available****: For example,* Student Grades/Report Card, Intervention Data, Discipline Data (if applicable), Copies of teacher data/behavior tracking (if applicable).

Revised 07/2022

Date: _____

Fort Bend ISD: Referral for Full and Individual Evaluation

Student Name: _____ ID#: _____ Grade: _____
Campus: _____ Teacher(s): _____
Schedule: *Lunch*: _____ *Recess*: _____ *Ancillary*: _____
**Fill in the schedule above or attach a copy of campus schedule*

Student referred by: □ RTI committee □ 504 committee □ Parent

Must include the following with this referral*:*
□ Passed Vision/Hearing Screening
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Academics: *what type of academic problem(s) does this student have?*
□ Reading - Fluency: _____
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□ Math - Calculation: _____
□ Writing: _____

Speech Concerns*:* Yes/No
□ Articulation: _____
□ Language: _____
□ Pragmatics: _____
□ Fluency: _____
□ Voice/Other: _____

Behavior: *What type of behavior problem(s) does this student have?*
□ Aggression: _____
_____
□ Anxiety/Depression: _____
_____
□ Social Skills: _____
_____
□ Outside Diagnoses: _____
□ Other: _____
_____

Other:
□ DHH: audiogram & ENT report: _____ □ VI: Texas State Eye Report: _____
□ Orthopedic Impairment (OI)/Other Medical: _____
□ OT/PT: _____
□ Assistive Technology: _____

****Please include any other supporting documents that are readily available****: For example,* Student Grades/Report Card, Intervention Data, Discipline Data (if applicable), Copies of teacher data/behavior tracking (if applicable).

Revised 07/2022

Referral to the Regional Day School Program for the Deaf (RDSPD) IEP Supplement

Student Name: Enter student name Date of IEP Meeting: Enter date

The ARD committee has determined that this student's placement will be:
Enter name of school
School District where school is located:
Enter name of school district
Regional Day School Program:
Brazoria-Fort Bend Regional Day School Program for the Deaf
☐ Yes ☐ No This is the school which this student would attend if not disabled.
If no, explain:
☐ Yes ☐ No Click or tap here to enter text.
List needs that local or regional program cannot meet:
Choose an item.

Describe how recommended placement will meet those needs.
Setting provides a teacher trained in the area of deafness to give instruction which will meet the student's IEP needs for <<expressive and receptive language development>>.

If this student is referred to a Regional Day School Program for the Deaf, the IEP Committee determined that the hearing loss:
☐ severely impairs linguistic processing through hearing even with recommended amplification, and
☐ adversely affects educational performance, as documented by the following:
☐ Audiological Report
☐ Otological Report
☐ Communication Assessment Report
☐ Full and Individual Evaluation Report
☐ Language Assessment
☐ Educational Performance Levels
☐ For referral of out-of-district RDSPD, an IEP report was sent to receiving school district.

Date: _____
Re-Evaluation Due Date: _____

SCORE MEETING PLANNING FORM

Student Name/ID: **Grade:**
Campus: **Current Eligibility:**

LANGUAGE: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

PHYSICAL: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

SOCIOLOGICAL: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

EMOTIONAL/BEHAVIORAL: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

Date: _____
Re-Evaluation Due Date: _____

COGNITIVE/INTELLECTUAL: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

ADAPTIVE BEHAVIOR: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

EDUCATIONAL/DEVELOPMENTAL: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

ASSISTIVE TECHNOLOGY: Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

VOCATIONAL (if applicable) : Additional Assessment Needed ☐ Yes ☐ No

[Use text boxes to determine which assessment instruments may be used to assess student.]

Date: _____
Re-Evaluation Due Date: _____

Staffing Members:

Name	Role	Signature