Deaf/Hearing Loss: Accommodation Support Form

NOTE: ***Please type or print your answers on this form.***

Student Information

Student Name:_____
Student ID Number:_____
Campus Address:_____
Local Phone Number:_____
Date of Birth:_____
Date of Evaluation:_____

Type of Hearing Loss

Type of Hearing Loss	Ear Affected		
☐ Sensorineural	☐ R	☐ L	☐ R&L
☐ Conductive	☐ R	☐ L	☐ R&L

Cause of Hearing Loss			
☐ Ear canal obstruction (Conductive)	☐ R	☐ L	☐ R&L
☐ Middle ear abnormalities (Conductive)	☐ R	☐ L	☐ R&L
☐ Genetic (Sensory)	☐ R	☐ L	☐ R&L
☐ Disease or illness (Sensory)	☐ R	☐ L	☐ R&L
☐ Medications (Sensory)	☐ R	☐ L	☐ R&L
☐ Physical Trauma (Sensory)	☐ R	☐ L	☐ R&L
☐ Long term exposure to environmental noise (Sensory)	☐ R	☐ L	☐ R&L

Please give brief explanation of cause._____

Severity of Loss

☐ No hearing loss	☐ R	☐ L	☐ R&L
☐ Mild	☐ R	☐ L	☐ R&L
☐ Moderate	☐ R	☐ L	☐ R&L
☐ Moderately Severe	☐ R	☐ L	☐ R&L
☐ Severe	☐ R	☐ L	☐ R&L
☐ Profound	☐ R	☐ L	☐ R&L

Age of Onset

Age of onset_____ ☐ Pre-lingual ☐ Post-lingual

Evaluation Tools

Please attach audiogram along with an interpretive summary.

Impact of Hearing Loss on Academic Functioning

Please describe the effects of the hearing loss on academic functioning._____

Prescribed Treatment

Please list prescribed treatments, such as hearing aids, cochlear implant, speech therapy, etc. and any effects the treatment may have on functioning._____

Recommendations for Accommodations/Referrals

- ☐ Note taking assistance
- ☐ Front Row Seating
- ☐ Clear view of instructor's lips
- ☐ FM listening device
- ☐ Verbal instructions given in a written format
- ☐ Sign language interpreters
- ☐ Closed captioned videos
- ☐ Real-time captions of class
- ☐ Email to facilitate communication
- ☐ Strobe light alarm system in residence hall room
- ☐ Referral for personal counseling
- ☐ Referral for time management skills training
- ☐ Referral for study skills training
- ☐ Referral for organizational skills training
- ☐ Referral for test taking skills training
- ☐ Referral for further assessment. Please indicate all that apply
  - ☐ Alcohol and drug
  - ☐ Depression
  - ☐ Learning disability
  - ☐ Anxiety
  - ☐ Other. Please list._____

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Evaluator Information

Evaluator Name:_____
Evaluator Title:_____
Evaluator Signature:_____
Address:_____

_____
Phone Number:_____
Fax Number:_____
Email Address:_____