

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE

**AUDIOLOGY PREASSESSMENT CHECKLIST**

(Complete **ONLY** if an audiology evaluation is needed as part of a comprehensive evaluation)

STUDENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

FORM COMPLETED BY: \_\_\_\_\_

PLEASE CIRCLE **YES** OR **NO** IN RESPONSE TO THE FOLLOWING:

- |     |  |     |    |
|-----|--|-----|----|
| 1.  | To your knowledge has this child had chronic middle ear problems?                            | Yes | No |
| 2.  | Does child's ability to respond to speech or noise change from day to day?                   | Yes | No |
| 3.  | Does child seem to hear but not understand?  | Yes | No |
| 4.  | Does child use a voice that is louder or softer than normal?                                 | Yes | No |
| 5.  | Does child have more difficulty with oral directions than with written directions?           | Yes | No |
| 6.  | Does child have preferential seating?  | Yes | No |
| 7.  | Is child easily distracted when background noise is present?                                 | Yes | No |
| 8.  | Are there delays or problems with speech and language skills?                                | Yes | No |
| 9.  | Does the child often give wrong answers to questions or fail to carry out simple directions? | Yes | No |
| 10. | Does child need statements and directions repeated more often than the average student?      | Yes | No |

Other comments you feel might be of help:

Thanks for your concern. The results of the evaluation will be shared with you.