



Please use above fax or address

Request for FM Equipment and/or Support

A **COMPLETED** request includes: Request for FM Equipment/Support Audiology Report Permission-to-Share Form

Office Use Only: Date **Completed** Request Received: _____

S.D. # _____ SD Name _____ School _____

Student Name: _____ D.O.B _____ Grade _____ P.E.N. _____

If student's referral DOES NOT involve requesting assistive listening devices, please go to Section 2, on Page 2

Contact Person: (for questions concerning this request) _____

Position: _____ Ph: _____ Email: _____

Student Hearing Aid Information:

Hearing Aid: Make _____ Model _____ Unilateral or Bilateral

Cochlear Implant: Make _____ Model _____

Equipment Being Requested: Please check box(s)

Channel: _____

Receiver: One Two MLX MLXS MLxi MLxi-Baha Freedom Edulink Mylink Easylistener

Transmitter: Inspiro Easylink Plus Easylink TX2 TX3 Easylistener

Special Requests: _____

Audiologist: Please sign below if you are the current audiologist and are certifying that the equipment being requested is compatible with student's hearing aid:

Date: _____ Name: _____ Signature: _____
(print)

School District Authorization:

Auditory Outreach equipment and accessories are on loan to the school and/or school district. When program equipment or accessories are lost, or damaged beyond use, the school and/or school district agrees to compensate Auditory Outreach for replacement cost(s) of the equipment; and requests the equipment be loaned for the above student through the Auditory Outreach program.

Name: _____ Position: _____
(School/School District Signing Authority)

Signature: _____ Date: _____

Estimated Replacement Costs:

Transmitters: Inspiro-\$1325 Other Types-\$699

Receivers: MLxs-\$830 Mylink-\$650 MLxi-\$1075 MLx-\$767 MLxi-Baha-\$1275 Edulink-\$970 MLxs-Baha-\$1023 Freedom-\$1799

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1. Are other students in the school using personal FM?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you know of any specific channels in the school that have interference problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which channels? _____	
3. Does the District/School require in-service to ensure that this student obtains maximum benefit from the assistive listening devices being requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who should we contact to arrange in-service? Name: _____ Ph#: _____	
4. Who will be the contact for answering questions regarding equipment function and functional benefit for the student?	
Name: _____ Ph: _____	

Ship Equipment To: _____
(Name, Address)

Section 2 . . . Consultation/Support Services

Auditory Outreach includes: Audiologist, Speech Language Pathologists, Hearing Resource Teacher and Technical Support.

Please Note: **Speech Language Pathologist Services are provided specifically for students with Cochlear Implants, or for students who are candidates for Cochlear Implants. These SLP services are available to support schools/districts, if not available locally.

Please outline, in as much detail as possible, the support you would like to receive from the Auditory Outreach Team. Please note which questions you would like answered, and specific problems or areas of concern our team members may be able to address. As well, please provide additional documentation, which would help us with supporting your request.

Contact Person: (for questions concerning Consultation/Support Services request) _____
Position: _____ Email: _____

School/District Authorization for Consultation/Support Services:	Date: _____
Name: _____	Position: _____
Signature: _____	