New Jersey Department of Health
Special Child Health and Early Intervention Services
PO Box 364
Trenton, NJ 08625-0364

REQUEST FOR HEARING AIDS

Name, Last First Middle		Hospital or Facility Requesting Services
Address		Address
City County Zip Code		City County Zip Code
Telephone No. (Incl. Area Code)	Date of Birth	Telephone No. (Incl. Area Code)

The family agrees to **$** _____ family financial participation (see Guidelines).

Significant History

Describe Communication Status

Habilitative/Rehabilitative Plan and Recommendations

Hearing Aid Recommendation *(Specify type, mold, telecoil)*

Right Ear:

Left Ear:

Audiologist must notify dispenser of referral and direct that estimate of cost be sent to SCHEIS

Hearing Aid Dispenser to Whom Child is Referred:

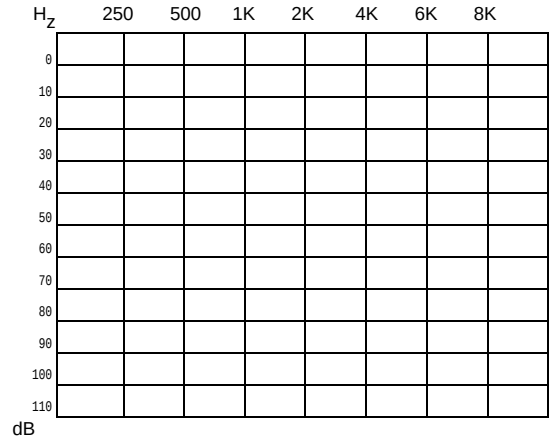
Telephone No.:

Pure Tone Audiometry

Legend
ASHA - 1974

AC	R	L
Unmasked	o	x
Masked	Δ	□
No Response	↙	↘
BC		
Unmasked	<	>
Masked	[	]
No Response	↙	↘
Soundfield	S	

	R	L
SRT	____	____
Discrim.at _____ SL	____	____



NOTE: For this request to be processed, the following must be either on file at SCHEIS or submitted to SCHEIS:
- Registration (SCH-0)
- Socio-Economic Form (CH-9)
- Income Verification

Aural Acoustic – Immittance

Tympanometry

Right Ear: Left Ear:

Reflex

Right Ear Stimulated

500	1KHz	2KHz	4KHz	
____	____	____	____	____

Left Ear Stimulated

500	1KHz	2KHz	4KHz	
____	____	____	____	____

Pre and Post Amplification Data for Recommended Aid (Use objective measurements.)

Stimuli	Unaided	Aided

FOR STATE USE ONLY

Signature of Physician	Date	Signature of Audiologist (CCC-A)

SCH-13
JUL 12

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