

## South East SELPA

### CHECKLIST FOR A REFERRAL TO THE PROGRAM FOR STUDENTS WITH HEARING IMPAIRMENTS

To refer a student for evaluation for Deaf and Hard of Hearing services, please follow these steps:

- Complete the "Referral for Deaf and Hard of Hearing Services" form
- Complete the "Authorization for Release of Medical/Educational Information for Students"
- Have the student's parents complete and sign that form with the following information:
  - Audiologist's name, address and telephone number
  - Authorization for the audiologist to release information to:  
DHOH Teacher  
South East SELPA Program  
3434 Marten Avenue, San Jose, CA 95148  
Fax: 408-532-9311
- Attach any available medical reports
- Attach the audiologist report, completed within the past year
- Attach any available IEPs
- Send all information to:  
Michele Villarreal  
Program Administrator  
South East SELPA Program for Students with Visual Impairments  
3434 Marten Avenue  
San Jose, CA 95148  
Fax: 408-532-9311  
Email: [mvillarreal@mpesd.org](mailto:mvillarreal@mpesd.org)

After reviewing the information, the DHOH Teacher will contact the referring party. The DHOH Teacher will verify the student has a visual impairment. To be eligible for special education a pupil must have a hearing impairment that adversely affects his or her educational performance.

**South East SELPA  
Program for Students with Hearing Impairments  
REFERRAL FOR DEAF AND HARD OF HEARING (DHOH) SERVICES**

**Child's Name:**

**Date of Birth:**

**Age:**

**Grade:**

**Address:**

**Father/Guardian:**

**His Phone Numbers:**

**His Email:**

**Mother/Guardian:**

**Her Phone Numbers:**

**Her Email:**

**Teacher:**

**Teacher's email:**

**Referring party:**

**Referring party's email:**

**District:**

**School:**

**Address:**

**Telephone:**

**Fax:**

**Does the Student Wear hearing aids or any other assistive listening devices?**

**Student's Audiologist:**

**Address:**

**Telephone:**

**Fax:**

**Please describe:**

- 1. The reason for referral, including specific observations:**
  
- 2. Student's educational performance:**
  
- 3. Student's classroom behavior:**
  
- 4. Student's strengths:**

**Referring Party:**

Name	Title	Signature	Date
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**Principal/Prog Sp/Dir:**

Name	Title	Signature	Date
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**SANTA CLARA COUNTY**  
**SPECIAL EDUCATION LOCAL PLAN AREA**  
**HIPAA PRIVACY AUTHORIZATION FOR**  
**RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS**

Student Name \_\_\_\_\_

Medical Record Number/ID Number \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

PERSON/ORGANIZATION INFORMATION WILL BE REQUESTED FROM:	PERSON/ORGANIZATION INFORMATION WILL BE SENT AND/OR DISCLOSED TO:
District:	District:
Name:	Name:
Address:	Address:
City/State/Zip	City/State/Zip:
Telephone: Fax:	Telephone: Fax:

**Check box to specify information requested and to be released:  
(Parent/Guardian to initial)**

- |   |  |
|---|--|
| <input type="checkbox"/> Psycho-educational evaluations/records<br><input type="checkbox"/> Speech & Language records<br><input type="checkbox"/> Mental health records<br><input type="checkbox"/> Cumulative/Educational File<br><input type="checkbox"/> Medical records pertaining to _____<br><input type="checkbox"/> Other records (Specify) _____ | <input type="checkbox"/> Health & Developmental<br><input type="checkbox"/> Vision evaluations<br><input type="checkbox"/> Hearing/Audiological evaluation<br><input type="checkbox"/> Birth records |
|---|--|

**DESCRIPTION OF EACH PURPOSE FOR THE USE OF RELEASE OF THE  
INFORMATION**

The person and/or organization who receives the information authorized on this form may only use it for the following educational purposes:

- Eligibility     
 Educational Planning     
 Health Services     
 Transition  
 Other: Specify \_\_\_\_\_

**SANTA CLARA COUNTY**  
**SPECIAL EDUCATION LOCAL PLAN AREA**  
**HIPAA PRIVACY AUTHORIZATION FOR**  
**RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS**

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: \_\_\_\_\_ (date)

**I understand** that the District and/or Representative shall have full authority to request and receive information in regards to my child as stated above and within the effective timeline. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the school district representative requesting the information. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

**I understand** that health information used or disclosed pertaining to this authorization may be subject to re-disclosure by the receiving agency and that the information requested may no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

**I understand** that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment, except under specific circumstance in the case of the request for physician orders, in accordance with *Education Code Section 49423.5* to provide specialized physical health care services and/or care to students with health conditions (for example: asthma, diabetes, epi-pen, gastrostomy feeding, medications, etc.) during school hours.

I consent to the release of the information indicated above and acknowledge that I have received a copy of this release; **A copy of this authorization is considered valid.**

\_\_\_\_\_  
**Parent\* Signature**

\_\_\_\_\_  
**Date**

\* *“Parent”* may refer to any person having legal custody of the child (eg:: biological, adoptive, or foster parents); any adult student without a guardian or conservator; a person acting as the child’s parent if neither the parent nor guardian can be notified of the educational actions under consideration; or an appointed surrogate parent. *“Parent”* does not include a nonpublic, nonsectarian school or agency under contract with LEA. [EdCode 56028]