REQUEST FOR SCREENING SERVICES

AUDIOMETRIC / VISION TECHNICIAN

School*: _____ Date: _____

Resident District Name / #: _____ Requested by: _____

***Please use one request sheet per school.**
***Please include additional information that may help in locating or understanding the student (e.g. Life Skills, glasses, etc.).**

**********************FOR OFFICE USE ONLY*********************

Student's Name	Grade	Birth Date	Service Requested V	Service Requested H	Date Needed	Date Completed	Results V	Results H	Rescreen V	Rescreen H	Date Referred	Notes

Comments:

**************** FOR OFFICE USE ONLY*********************
Copy at School:
Email:
Spreadsheet:
Screener:
Billing: