

Equipment Request - Cochlear Implant Student - page 1 of 2

Student NAME: _____ **Birthdate:** _____
(day/month/year)

COMPLETED Request for Equipment forms (pages 1 & 2) must be sent together including:

Recent Audiology Report Permission-to-Share Form

Additional information (if incomplete): _____

All sections of this page must be completed by the audiologist/ clinic. Incomplete forms will result in delays.

Student's Hearing Device(s)

Hearing Aid: R L Make _____ Model _____

Cochlear Implant: RIGHT Make _____ Model _____

Cochlear Implant: LEFT Make _____ Model _____

Equipment Being Requested

Receiver: Roger 20 (Colour*: Black Brown Grey Sand) Roger 21 Roger X

Other: _____

One

Two

**Roger 20 colour availability from loan bank. Black will be issued by default if colour not indicated above.*

Transmitter: Roger Touchscreen Roger On Cochlear Mini Mic 2+ Oticon EduMic

Other: _____

Special Requests: N7/N8 Monitor Earphones Remote Control Belt Clip/Boom Mic for Roger Touchscreen

Other: _____

CI Information Required

1. Recommended settings for RM use: Program ____ Vol ____ Sens ____

2. Processor controls: Locked Unlocked

3. Processor indicator lights for RM: On Off

4. For Cochlear MM2+ requests only: If paired at hospital, home wireless accessories paired to Channel ____

CI Audiologist Authorization: Please sign below to certify this student's readiness for assistive listening equipment.

Considering this student's hearing history and experience with the current cochlear implant(s), it is recommended the student start using the selected equipment as of _____.
(day/month/year)

Date: _____ Name: _____
(please print)

Signature: _____

Equipment Request - Cochlear Implant Student - page 2 of 2

Student NAME: _____ Birthdate: _____
(day/month/year)

COMPLETED Request for Equipment forms (pages 1 & 2) must be sent together including:

Recent Audiology Report Permission-to-Share Form

All sections of this page must be completed by the school team. Incomplete forms will result in delays.

Student's School Information

SD #: _____ SD Name: _____ PEN (required): _____

School: _____ Grade: _____

Additional Information

1. Is the student bimodal (also wears a hearing aid)? Yes No

If yes, please provide name of Public Health audiologist & clinic: _____

2. Are there students in the same school using personal RM? Yes No

3. Is there a sound field in the student's classroom? Yes No

School/District Shipping Address following Validation by AO-PRP Audiologist:

School/District Contact regarding validation, equipment and functional benefit for the student:

Name: _____

Position: _____

Phone: _____

Email: _____

School District Authorization

Auditory Outreach equipment and accessories are on loan to the school and/or school district for educational use by the student listed above. 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. The equipment is due for return to Auditory Outreach when the student transfers to another school district or independent school, or graduates from your district.

Date: _____ Position: _____

Name: _____ Signature: _____
(please print)

Phone: _____ Email: _____

Estimated Replacement Costs

Receivers: Roger 20, Roger 21: \$2100; Roger X \$1350

Transmitters: Roger Touchscreen, Roger On \$1750; Cochlear Mini Mic 2+ \$382.50; Oticon EduMic \$1100