

# Deaf/Hearing Loss: Accommodation Support Form

**NOTE: Please type or print your answers on this form.**

## Student Information

Student Name: \_\_\_\_\_  
Student ID Number: \_\_\_\_\_  
Campus Address: \_\_\_\_\_  
Local Phone Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Date of Evaluation: \_\_\_\_\_

---

---

## Type of Hearing Loss

Type of Hearing Loss	Ear Affected		
<input type="checkbox"/> Sensorineural	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Conductive	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L

Cause of Hearing Loss	Ear Affected		
<input type="checkbox"/> Ear canal obstruction (Conductive)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Middle ear abnormalities (Conductive)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Genetic (Sensory)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Disease or illness (Sensory)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Medications (Sensory)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Physical Trauma (Sensory)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Long term exposure to environmental noise (Sensory)	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L

Please give brief explanation of cause. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

---

## Severity of Loss

<input type="checkbox"/> No hearing loss	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Mild	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Moderate	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Moderately Severe	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Severe	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L
<input type="checkbox"/> Profound	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> R&L

---

---



## Recommendations for Accommodations/Referrals

- Note taking assistance
  - Front Row Seating
  - Clear view of instructor's lips
  - FM listening device
  - Verbal instructions given in a written format
  - Sign language interpreters
  - Closed captioned videos
  - Real-time captions of class
  - Email to facilitate communication
  - Strobe light alarm system in residence hall room
  - Referral for personal counseling
  - Referral for time management skills training
  - Referral for study skills training
  - Referral for organizational skills training
  - Referral for test taking skills training
  - Referral for further assessment. Please indicate all that apply
    - Alcohol and drug
    - Depression
    - Other. Please list. \_\_\_\_\_
    - Learning disability
    - Anxiety
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 

### Evaluator Information

**Evaluator Name:** \_\_\_\_\_

**Evaluator Title:** \_\_\_\_\_

**Evaluator Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

  

**Phone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_