

Audiological Record

Part A (To be completed by applicant)

Personal Data

Month	Day	Year
□ □	□ □	□ □
Date of Birth		

Name _____
Last First Middle Initial

Address _____
Number and Street City State/Province Zip/Postal Code (Country)

Email _____

Phone () _____
Home/Cell/VP (Circle One)

Deaf and hard-of-hearing applicants may submit this form or use an official audiogram (including history and speech recognition) from a certified audiologist.

Optional: Please indicate your preferred method of communication. Sign Language Speech Combination of both

Applicant: I give permission for my audiological records to be released to RIT/NTID. (If under 18, parent/guardian signature required.)

Signature _____

Parent/Guardian: I give permission for my son/daughter's audiological records to be released to RIT/NTID.

Signature _____

Part B (To be completed by certified audiologist, CCC-A)

All the information below is required for every applicant. Submitted **unaided** audiograms should be from within three years of the application date, or more recently if loss is progressive. **Please return this completed form as soon as possible.**

1. **Onset of hearing loss** At birth Other _____
Month / Year

2. **Cause of hearing loss** _____

3. **Hearing aid/cochlear implant information**

a. The applicant uses a hearing aid: All the time Only in classroom settings Never

b. The applicant uses a cochlear implant: All the time Only in classroom settings Never

c. The applicant uses an FM System: Only in classroom settings Never

	Right Ear	Left Ear
Make		
Model		
Style		
Serial #		
Age of aid/implant		

Applicant's Name _____
First Last Middle Initial

4. Audiometric Assessment (please list test results **without** amplification)

Date of Exam _____
Month /Day/ Year

Right Ear										
Frequency	125	250	500	750	1000	2000	3000	4000	6000	8000
Hearing Level	Air									
	Bone									

Left Ear										
Frequency	125	250	500	750	1000	2000	3000	4000	6000	8000
Hearing Level	Air									
	Bone									

5. Otologic history (surgery, middle ear infections, dizziness, tinnitus)

6. Speech Recognition

	Right	Left
% Correct		
Presentation Level		
Test Materials		
Recorded		
Live Voice		
Visual Cues Used		

Please attach any additional supporting documents.

Signature _____
Audiologist

Name _____
(Please print)

Title/Position _____

Address _____
Number Street

City State Zip

Email _____

Phone () _____ Fax () _____

Please mail or fax completed form to:

Rochester Institute of Technology
 NTID Office of Admissions
 52 Lomb Memorial Drive
 Rochester, New York 14623-5604
 585-475-6700
 585-743-1366 (Videophone)
 866-644-6843 (Toll free)
 585-475-2696 (Fax)