Kansas Department for Children and Families
Rehabilitation Services

STATE AUDIOLOGICAL CONSULTATION REPORT OF CONTACT

Counselor Name: _____ Date: _____

Counselor Address: _____

Counselor Phone: (____) _____

Client Name: _____ Age: _____

Hearing Aid History:

Age began wearing a hearing aid: _____

Make, model and age of current aid: _____

_____

_____

Source of referral to VR: _____

Vocational objective: _____

What does the client need to be able to hear on the job including a description of the work environment: _____

_____

_____

_____

Questions for the Consultant:

Consultant Response and Recommendations:

_____ _____

Audiological Consultant signature Date

Counselor Reminder: **Consultant**

Attach the following for consultant:
Section Ib Hearing Exam and Section Ia if applicable
ENT/Audiology/Physician Reports
Stamped Self-Addressed Envelope

Reminder:

Submit a copy of the signed Report of Contact of Kansas Rehabilitation Services Central Office.