Section 8 / Part 40
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State Audiological Consultation Report of Contact

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

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