

ADELAIDE Hearing CONSULTANTS

Audiology & Educational Consultants

Suite 1, 601-603 Anzac Highway,
GLENELG NORTH SA 5045
Phone: 8376 0999
Fax: 8376 0255

51 Angas St,
ADELAIDE SA 5000
Phone: 8410 2900
Fax: 8410 2902

Dear Parent/Guardian,

Thank you for making an appointment for your child to have an auditory processing assessment.

The following two questionnaires will provide us with useful information about your child's listening and other behaviours and contribute to our assessment of your child's auditory processing (AP) abilities. If your child has a diagnosed medical condition or intellectual delay/disability, please contact this office to discuss whether a CAP test can be performed.

Please complete the Parent Questionnaire and bring it to the AP assessment appointment. Also, it would be helpful if you could bring copies of any recent reports, i.e. psychology, speech pathology.

Please also ask your child's class teacher to complete the Teacher Questionnaire. He or she may either return it via you or post/fax it directly to our office.

The cost of the assessment is \$350.00 and is not claimable from Medicare. We suggest you check with your Private Health Fund regarding any refund available from them. Payment of the account is requested on the day of the assessment.

As you can appreciate, there is a long waiting list for these services. If you decide not to attend this appointment, we ask that you give us at least 48 hours notice. Non-attendance (without notice) will result in a \$100 cancellation fee.

Thank you for your assistance. We look forward to meeting with you and your child.

Yours sincerely,

Dr Judith Boswell
Audiologist

Mrs Nichole Govier
Speech Pathologist

Mr David May
Audiologist

Ms Holly Veale
Audiologist

**CENTRAL AUDITORY PROCESSING DISORDER
PARENT QUESTIONNAIRE**

CHILD'S NAME _____ DOB _____ AGE _____

PARENT'S NAMES _____

ADDRESS _____

T'PH (AFTER HOURS) _____ (BUSINESS HOURS) _____

EMAIL ADDRESS: _____

Is the child of Aboriginal or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander

WHO REFERRED CHILD? _____

GP'S NAME & ADDRESS _____

SCHOOL NAME _____ YEAR _____ TEACHER _____

BACKGROUND INFORMATION

1. Please tick box if your child has a history of any of the following:

- speech or language problems
- middle ear infections
- ear / nose / throat surgery
- known hearing problems
- fits or seizures
- vision problems
- major head trauma
- serious illnesses
- is your child right or left handed? LEFT / RIGHT / MIXED
- any diagnosed conditions

2. Has any family member had speech or language problems or learning difficulties? Yes

Please state their relationship to your child

3. Tick box if your child seen any of the following specialists. Please provide name & date of assessment:

- Audiologist
- Speech Pathologist
- Psychologist/Guidance Officer
- Occupational Therapist
- Optometrist
- Ear, Nose and Throat Specialist (ENT)
- Paediatrician

(please bring any professional reports to your appointment)

EDUCATIONAL INFORMATION

Please rate how your child performs in these subjects

Rating Scale				
1	2	3	4	5
below ave.		ave.		above ave.

• reading	1	2	3	4	5
• spelling	1	2	3	4	5
• written expression	1	2	3	4	5
• maths	1	2	3	4	5
• art	1	2	3	4	5
• music	1	2	3	4	5
• sport	1	2	3	4	5

LANGUAGE, LISTENING AND LEARNING SKILLS

1. Please tick any of the following which apply to your child. Does your child:

- have difficulty following simple instructions
- have difficulty following complex or long instructions
- ask for questions or instructions to be repeated?
- confuse similar sounding words, e.g. pat / bat?.....
- have difficulty understanding jokes?
- understand better when spoken to individually?
- realise when s/he is not understanding someone or something?

2. Please tick any of the following which apply to your child when s/he is answering questions or following instructions:

- responds inconsistently
- responds slowly
- requires you to speak more slowly to help his/her understanding?.....
- requires you to look at them when you speak to help his/her understanding?

3. Please tick any of the following which describe your child telling a story or describing something:

- confuses the order of events
- lacks detail
- repeats him/herself
- speech is unclear

4. Please tick any of the following which apply to your child. Does your child:

- often reverse letters or words in reading
- often reverse letters or words in writing
- dislike books / reading?

BEHAVIOUR

1. Please tick any of the following which describe your child:

- easily distracted
- has difficulties concentrating
- day dreams, is not 'with it' at times
- cannot relate what is heard to what is seen
- forgets what is said in a few minutes
- generally forgetful and disorganised
- forgets homework instructions
- performs better when shown what to do rather than being told.....
- has difficulty completing tasks
- always on the go or fidgets/squirms
- talks excessively
- acts before thinking
- has trouble relating to peers
- anxious
- dislikes or avoids noise
- often tired or lethargic
- clumsy
- avoids some tasks
- dislikes school
- doesn't cope well with change

What things does your child do best?

What concerns you most about your child?

Authority to release confidential audiological information:

I _____ (*print your name*) hereby authorise the release of information regarding my child's audiological assessment to other service providers. This information is to be used to manage my child's case and to assist in my child's rehabilitation/training program.

Signature _____ Date ____/____/____

ADELAIDE Hearing CONSULTANTS

Audiology & Educational Consultants

Suite 1, 601-603 Anzac Highway,
GLENELG NORTH SA 5045
Phone: 8376 0999
Fax: 8376 0255

51 Angas St,
ADELAIDE SA 5000
Phone: 8410 2900
Fax: 8410 2902

Dear Teacher

Please find enclosed a questionnaire for one of your students. The aim of this questionnaire is to provide useful information about your student's listening and other behaviours. This information will contribute to the assessment of the student's auditory processing abilities.

Please complete the "*Teacher Questionnaire*" and return it to the student's parents so that they can bring it to the assessment appointment, or post/fax it directly to our office.

Please ensure that the student and school details are completed on the questionnaire to allow easy matching to appointments.

Thank you for your assistance.

Yours sincerely,

Dr Judith Boswell
Audiologist

Mrs Nichole Govier
Speech Pathologist

Mr David May
Audiologist

Ms Holly Veale
Audiologist

**CENTRAL AUDITORY PROCESSING DISORDER
TEACHER QUESTIONNAIRE**

CHILD'S NAME _____ DOB _____ AGE _____
 SCHOOL _____
 SCHOOL ADDRESS _____
 SCHOOL GRADE _____ DATE _____
 QUESTIONNAIRE COMPLETED BY _____

EDUCATIONAL INFORMATION

Rating Scale				
1	2	3	4	5
below ave.		ave.		above ave.

1. Compare the student's academic performance for the following subjects:

• Reading - decoding	1	2	3	4	5
• Reading comprehension	1	2	3	4	5
• spelling	1	2	3	4	5
• written expression	1	2	3	4	5
• maths	1	2	3	4	5
• art	1	2	3	4	5
• music	1	2	3	4	5
• sport	1	2	3	4	5

2. Rate the child's confidence in his/her own academic abilities 1 2 3 4 5

At school, has the student received :

- speech pathology services?..... currently / in the past / no
- psychological / guidance assessment?..... currently / in the past / no
- occupational therapy sessions?..... currently / in the past / no
- special education classes?..... currently / in the past / no
- negotiated education plan?..... currently / in the past / no
- LAP assistance?..... currently / in the past / no
- Any other services at school?..... currently / in the past / no

BEHAVIOUR

The student:

Rating Scale			
1	2	3	4
never/occasionally/often/always			

- | | | | | |
|---|---|---|---|--------------------------|
| 1. commences new tasks readily | 1 | 2 | 3 | 4 |
| 2. participates well in most tasks, activities and social situations | 1 | 2 | 3 | 4 |
| 3. works well independently | 1 | 2 | 3 | 4 |
| 4. works well in groups | 1 | 2 | 3 | 4 |
| 5. demonstrates the following behaviours when a task becomes difficult: | | | | |
| • generally completes tasks | 1 | 2 | 3 | 4 |
| • attempts to figure out meaning | 1 | 2 | 3 | 4 |
| • asks another student for assistance | 1 | 2 | 3 | 4 |
| • asks for repetition and/or more information when uncertain | 1 | 2 | 3 | 4 |
| 5. Please tick any of the following which describe this student: | | | | |
| • easily distracted | | | | <input type="checkbox"/> |
| • has difficulties concentrating | | | | <input type="checkbox"/> |
| • day dreams, is not 'with it' at times | | | | <input type="checkbox"/> |
| • cannot relate what is heard to what is seen | | | | <input type="checkbox"/> |
| • forgets what is said in a few minutes | | | | <input type="checkbox"/> |
| • generally forgetful and disorganised | | | | <input type="checkbox"/> |
| • forgets homework instructions | | | | <input type="checkbox"/> |
| • has difficulty completing tasks | | | | <input type="checkbox"/> |
| • always on the go or fidgets/squirms | | | | <input type="checkbox"/> |
| • talks excessively | | | | <input type="checkbox"/> |
| • acts before thinking | | | | <input type="checkbox"/> |
| • has trouble relating to peers | | | | <input type="checkbox"/> |
| • anxious | | | | <input type="checkbox"/> |
| • dislikes or avoids noise | | | | <input type="checkbox"/> |
| • often tired or lethargic | | | | <input type="checkbox"/> |
| • clumsy | | | | <input type="checkbox"/> |
| • avoids some tasks | | | | <input type="checkbox"/> |
| • dislikes school | | | | <input type="checkbox"/> |
| • doesn't cope well with change | | | | <input type="checkbox"/> |
| • shows confusion | | | | <input type="checkbox"/> |
| • shows anxiety | | | | <input type="checkbox"/> |

MEMORY

The student:

- retells stories and relate events
- remembers songs, rhymes and/or arithmetical sequences, e.g. counting by 5's to 100
- learns and retains new vocabulary and concepts
- rehearses information, i.e. says aloud to self
- consistently follows instructions
- consistently follows routines

Rating Scale			
1	2	3	4
never/occasionally/often/always			

1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4

SPEECH/LANGUAGE

The student:

- expresses him/herself easily
- is willing to contribute in class
- is successful in retelling an incident or joke
- responds to questions without undue hesitation
- responds appropriately to questions after a story
- is able to pronounce new words
- has good articulation of speech sounds
- relates what is heard to what is seen

Rating Scale			
1	2	3	4
never/occasionally/often/always			

1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4
1	2	3	4

LITERACY

Please tick any of the following that best describe the student:

- difficulty developing reading strategies, e.g. sounding out new words
- difficulty reading aloud
- uses finger or ruler to follow words when reading
- difficulty comprehending written text / stories
- reverses letters in written work, e.g. 'b' becomes 'd'
- confuses small words while reading, e.g. 'is' and 'it'

LISTENING AND ATTENTION

Please tick any of the following behaviours the student demonstrates:

- complains of sounds being too loud, e.g. music, speech, class activities
- is easily distracted by other sounds in the classroom
- has difficulty maintaining attention to individual tasks for an appropriate length of time
- does not seem to listen from the start
- does not attend to oral discussions, morning talks etc.
- day dreams, not 'with it' at times, attention drifts

Comments _____

COMPREHENSION

Please tick any of the following behaviours the student demonstrates:

1. understands what is said
 - one-to-one
 - in a group
2. looks uncertain following auditory information
3. requires shorter messages and instructions
4. requires repetition of instructions or information
5. is assisted if you slow down your speech
6. does not always realise when s/he is not understanding something

Comments _____

LEARNING ENVIRONMENT

Are there any features of the student's classroom (or other regular learning settings) which are sources of distraction or which prevent optimum learning, e.g. computer close by, major traffic areas, noisy air conditioner, overhead/slide projector?

- Do any children in your class currently use an FM listening System? YES / NO
- Do any children in your school currently use an FM listening System? YES / NO
- Is your classroom equipped with a classroom amplification system (microphone and speakers)? YES / NO

GENERAL INFORMATION

Do you think this student performs to the best of his/her ability at school?

YES / NO

What do you see as this student's strengths? _____

What do you see as this student's weaknesses? _____

THANK YOU FOR YOUR ASSISTANCE