Thank you for your interest in the University of Nebraska Cochlear Implant Program. A cochlear implant is designed for individuals with severe to profound hearing loss in both ears that receive little or no benefit from hearing aids. Cochlear implantation requires surgery followed by multiple visits for programming the cochlear implant system and aural (re)habilitation therapy.

An individual must undergo a series of evaluations to determine if a cochlear implant is an appropriate treatment for your child’s hearing loss. The evaluation process is extensive and involves assessments by the ear, nose, throat (ENT) doctor, audiologists, speech-language pathologist, and/or deaf educator. We will also need to consult with your child’s school or early interventionist during the evaluation process.

The first step in the evaluation process is to complete the intake packet that is enclosed. The following items must be completed prior to scheduling the appointment:

1. Case History form,
2. Release of Information form,
3. Copy of your child’s most recent hearing test results (audiogram), and
4. Referral from your child’s pediatrician for “medical, radiological, speech-language, social work and audiological evaluations for cochlear implant work-up”.

Your child’s pediatrician and audiologist can fax their materials to us at 402-472-3814. Upon receipt of all five items, you will be contacted regarding your child’s appointment time for the cochlear implant evaluation. The evaluation is conducted over a two day period which is usually on a Monday and Tuesday. It is very important that you bring your child’s hearing aids and earmolds to the evaluation. Once all the testing is complete, a decision regarding your child’s candidacy for cochlear implantation will be decided by the team members.

Enclosed you will find some general information about our program. If you would like additional information about the cochlear implant or our team, please call 402-472-2071.
# Child Case History

<table>
<thead>
<tr>
<th>Date</th>
<th>Referred By</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Middle Initial</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Age</td>
</tr>
<tr>
<td>Child’s Primary Insurance</td>
<td>Policy Number</td>
</tr>
<tr>
<td>Mother’s First and Last Name</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td>Cell</td>
</tr>
<tr>
<td>Father’s First and Last Name</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td>Cell</td>
</tr>
<tr>
<td>What name does your child like to be called?</td>
<td></td>
</tr>
<tr>
<td>Who is responsible for the care of this child?</td>
<td></td>
</tr>
<tr>
<td>Does this child have any brothers or sisters? If so, what are their names and ages?</td>
<td></td>
</tr>
</tbody>
</table>

## Other Professionals

<table>
<thead>
<tr>
<th>Pediatrician’s Name</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>ENT’s Name</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Audiologist’s Name</td>
<td>Phone Number</td>
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<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Speech Therapist’s Name</td>
<td>Phone Number</td>
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<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Teacher’s Name</td>
<td>Phone Number</td>
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<td>Address</td>
<td></td>
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<tr>
<td>Early Interventionist’s Name</td>
<td>Phone Number</td>
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<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>
**Hearing History**
At what age was the hearing loss first diagnosed? _________________________________________
Do you know what caused the hearing loss? Yes   No    If yes, what?_____________________
What diagnosis have you received regarding the degree of hearing loss?____________________
__________________________________________________________________________________
Which is the better ear? Right    Left    Same    Not Sure
Is there a family history of hearing loss? Yes     No        If yes, tell us________________________
__________________________________________________________________________________

**Health History**
Was the pregnancy full term with normal delivery? Yes   No   If no, tell us why_______________
Birth Weight _________________Length _______________Apgar Score_________________
Have you noticed any problems other than hearing? If so, please describe____________________
__________________________________________________________________________________
Does your child have a history of ear infections? Yes   No   If yes, how many per year?____
Has your child’s vision been evaluated? Yes   No   If yes, when and what were the results?
__________________________________________________________________________________
Has your child ever had a developmental or psychological evaluation?   Yes    No (If yes, please
attach a copy of the evaluation results.)
At what age did your child: Babble_____________                  Sit Alone_________________
Walk alone__________________ Say first word_________________ Put Words together_______
Self feed_____________________    Toilet independently_____________________

**Hearing Aid History**
Does your child wear hearing aids?         Yes             No    If yes, which ear         R       L      Both
What is the make and model of the hearing aids?_____________________________________
On average, how many hours does your child wear the hearing aids each day?____________
How old are the current hearing aids?______________________________________________
Do you feel that your child benefits from the hearing aids?______________________________
Is there a change in your child’s behavior and amount of speech production when he/she is
wearing the hearing aids?   Yes     No   If yes, explain______________________________
Communication Information

Did your child babble or coo as an infant? Yes No
Does the child use his/her voice consistently? Yes No
Does the child vocalize more with the hearing aids on? Yes No
Does the child attempt to imitate speech? Yes No
Do your family members understand your child? Yes No
Can others understand your child? Yes No

Please circle any of the following ways your child communicates with others:

Speaks Gestures ASL Sign Language Cued Speech Other

What are your communication goals for your child?____________________________________
______________________________________________________________________________
______________________________________________________________________________

Expectations

What outcomes do you expect for the cochlear implant? _______________________________
______________________________________________________________________________
______________________________________________________________________________

Cochlear Implant History (Complete the following information if you did NOT receive your cochlear implant at the UNL Cochlear Implant Program.)

Hospital________________________________________ Surgeon__________________

Audiologist____________________________________ Phone____________________
Address______________________________________________________________________
Date of surgery______________________________ Activation date____________________
Description of activation experience
______________________________________________________________________________
______________________________________________________________________________

Rehabilitation services provided by cochlear implant program
______________________________________________________________________________
______________________________________________________________________________
Release of Information

I authorize the above named professionals to release information regarding my child to the Barkley Speech-Language and Hearing Clinic at UNL for the purpose of conducting a cochlear implant work-up.

___________________________________________  __________________________
Parent/Guardian Signature                                   Date

__________________________________________  _________________
Witness                                                        Date

Please return this form and a copy of your child's most recent audiogram to the address on the front of this form. Thank you.
Cochlear Implant Program
Barkley Memorial Center
4075 East Campus Loop
Lincoln, Nebraska 68503
402-472-2071 | 402-472-3814 (fax)

Team Members

Audiologists
Hannah Ditmars, Au.D., CCC-A
Kelly Pritchett, Au.D., CCC-A
Stacie Ray, Au.D., CCC-A
Josh Sevier, Au.D., CCC-A
Emily Wakefield, Au.D., CCC-A

CI Audiologist
Josh Sevier, Au.D., CI Program Coordinator

Vestibular Audiologist
Amanda Rodriguez, Au.D., Ph.D.

Speech-Language Pathologists
Katie Brennan, MS, CCC-SLP

Deaf Educator
Anne Thomas, Ph.D.
University of Nebraska Lincoln
Barkley Speech-Language

Candidacy Evaluations

**Audiological Evaluation**: A comprehensive hearing assessment will be completed with and without the hearing aids. This may require more than one visit. *It is essential that the individual brings his/her hearing aids and earmolds to the evaluation.*

**Sedated Auditory Brainstem Response and Otoacoustic Emissions Tests**: These tests are objective measures of hearing sensitivity. Some children require sedation to obtain these test results.

**Vestibular Evaluation**: This is a thorough assessment of the balance system located in the inner ear.

**CT Scan**: A specialized x-ray to evaluate the anatomy of the hearing organ. Some children are sedated for this procedure.

**Medical Examination**: The otologist/otolaryngologist will take a medical history, review the CT scan, and determine if there are any medical contraindications that would prohibit the surgery.

**Speech-Language Evaluation**: A formal and informal assessment of the person’s communication abilities *with his/her hearing aids* will be evaluated. Communication goals will be discussed at this appointment.

**Family Consultation**: For children, formal and informal evaluations of the child’s developmental milestones and capacity to learn will be assessed. Family expectations will also be discussed. *If your child has had a psychoeducational/developmental assessment, please include that report with this packet.*

**Educational Assessment**: The child’s school will be contacted regarding educational placement, support, and the need, if any, for cochlear implants.

Additional evaluations may be recommended based on the information obtained during the candidacy assessment.

After all the assessments are complete, the CI team members will meet and determine if the individual is a cochlear implant candidate. If the individual is determined to be a candidate, a surgery date will be scheduled. (In case of a child, he or she will need to be enrolled and attending appropriate therapy before a surgery date is scheduled.) Approximately two to four weeks after the surgery and medically cleared, the individual will need to return to the Barkley Center for cochlear implant programming. If the individual is not a candidate, then the individual will be contacted and alternative options will be discussed.