

**California Early Hearing Detection and Intervention Early Start Referrals**

Please send to: [NewbornReferrals@leadkfamilyservices.org](mailto:NewbornReferrals@leadkfamilyservices.org) · Fax: 916-282-2440



Referring Agency/Audiologist:

Name: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_

Check to acknowledge you are sending information to LEAD-K Family Services

Child's Name: _____		
First	Middle	Last
Gender: M <input type="checkbox"/> F <input type="checkbox"/> NB <input type="checkbox"/>	Birthdate: _____	Birth Hospital: _____
Primary Language of the Home: _____		Baby was in NICU? Yes <input type="checkbox"/> No <input type="checkbox"/>

Parent (Guardian) Name: _____		
First	Last	Relationship to Child
Contact: _____	_____	_____
Home or Cell # (Voice/TTY/VP)	Work #	Email
_____	_____	_____
Street	City	Zip

Parent (Guardian) Name: _____		
First	Last	Relationship to Child
Contact: _____	_____	_____
Home or Cell # (Voice/TTY/VP)	Work #	Email
_____	_____	_____
Street	City	Zip

Alternate Contact (Required): _____		
Name	Phone/Email	Relationship to Child
_____	_____	_____
Street	City	Zip

Date of Testing/Hearing Status Identified: _____ (mm/dd/yy)		Parent(s) informed of this referral to Early Start with hearing level/diagnosis information: Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>AUDIOLOGICAL INFORMATION INCLUDED WITH REFERRAL (optional):</b> <input type="checkbox"/> Audiology Report <input type="checkbox"/> ABR Report <input type="checkbox"/> Audiogram			
	<b>RIGHT EAR DB LEVEL: _____ (db)</b>	<b>LEFT EAR DB LEVEL: _____ (db)</b>	
<b>Hearing Level</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Moderately-Severe <input type="checkbox"/> Slight <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> Profound <input type="checkbox"/> Moderate	<input type="checkbox"/> Normal <input type="checkbox"/> Moderately-Severe <input type="checkbox"/> Slight <input type="checkbox"/> Severe <input type="checkbox"/> Mild <input type="checkbox"/> Profound <input type="checkbox"/> Moderate	
<b>Type</b>	<input type="checkbox"/> Sensorineural <input type="checkbox"/> Mixed <input type="checkbox"/> Conductive <input type="checkbox"/> Auditory Neuropathy <input type="checkbox"/> Permanent <input type="checkbox"/> Prolonged(3+ months) <input type="checkbox"/> Intermittent	<input type="checkbox"/> Sensorineural <input type="checkbox"/> Mixed <input type="checkbox"/> Conductive <input type="checkbox"/> Auditory Neuropathy <input type="checkbox"/> Permanent <input type="checkbox"/> Prolonged(3+ months) <input type="checkbox"/> Intermittent	
<b>Additional Information</b>	<input type="checkbox"/> Atresia <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> Right <input type="checkbox"/> Left	Other Diagnosis(please explain): _____	

Additional Notes:

To be filled out by LEAD-K Family Services:

LEAD-K Family Services: \_\_\_\_\_ HCC: \_\_\_\_\_ Regional Center (if applicable): \_\_\_\_\_

LEA: \_\_\_\_\_ Note to LEA, your contact for Deaf Coach services in your area is: \_\_\_\_\_