Early Start Referral
For Infants and Toddlers with Hearing Loss
California Department of Education
Deaf and Hard of Hearing Unit

Child's Name: _____ **Ethnicity:** _____
First Middle Last

Gender: ☐ M ☐ F **Birthdate:**_____ **Birth Hospital:** _____

Primary Language of the Home _____

Child's Address: _____
Street City Zip County

Mother's Name: _____
First Middle Last

Mother's Address: _____
(If different from above) Street City Zip County

Mother's Phone: _____
Home (Voice/TTY/VP) Work Ext. Cell Phone/Other

Father's Name: _____
First Middle Last

Father's Address: _____
(If different from above) Street City Zip County

Father's Phone: _____
Home (Voice/TTY/VP) Work Ext. Cell Phone/Other

Severity and Type of Hearing Loss			
	Right	**Left**	**Date Hearing Loss Confirmed**
Hearing Level	☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Profound	☐ Normal ☐ Mild ☐ Moderate ☐ Severe ☐ Profound	
Type of Hearing Loss	☐ Sensorineural ☐ Conductive ☐ Mixed ☐ Auditory Neuropathy	☐ Sensorineural ☐ Conductive ☐ Mixed ☐ Auditory Neuropathy	

Infant has Atresia: ☐ Y ☐ N **Bilateral** **Unilateral:** ☐ Right ☐ Left (Check one)

Other diagnoses related to hearing loss: _____

Was child in NICU? ☐ Y ☐ N **Is child in foster care?** ☐ Y ☐ N

Examining Audiologist: _____

Referring Agency Name: _____

Referring Agency Phone No.: _____ Ext **:** _____ Fax: _____

Are parents aware of the child's hearing loss? ☐ Y ☐ N

Are parents aware of the referral to Early Start? ☐ Y ☐ N

Fax to (916) 445-4550, Attn. Nancy Grosz Sager at California Department of Education,
or call (916) 327-3868 or 1-866-505-9388 to leave referral information.

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