

Early Start Referral
To Determine Appropriate Services For Infants and Toddlers who are Deaf or Hard of Hearing
California Department of Education Deaf and Hard of Hearing Unit
PLEASE TYPE OR PRINT CLEARLY

Child's Name: _____
First Middle Last

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

Primary Language of the Home: _____

Child's Physical Address: _____
Street City Zip County

Parent (Guardian) Name: _____
First Last Relationship to child

Parent's (Guardian's) Contact: _____
Home or Cell (Voice/TTY/VP) Work E-mail Address

Parent (Guardian) Name: _____
First Last Relationship to child

Parent's (Guardian's) Contact: _____
Home or Cell (Voice/TTY/VP) Work E-mail Address

Alternate Contact: _____
(REQUIRED) Home or Cell (Voice/TTY/VP) Work E-mail Address

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

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

	Left	Right	
Hearing Level	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Date Hearing Status Identified
	<input type="checkbox"/> Slight	<input type="checkbox"/> Slight	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Mild	
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	
	<input type="checkbox"/> Moderately-Severe	<input type="checkbox"/> Moderately-Severe	
	<input type="checkbox"/> Severe	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Profound	<input type="checkbox"/> Profound	
Type of Hearing Loss	<input type="checkbox"/> Sensorineural	<input type="checkbox"/> Sensorineural	
	<input type="checkbox"/> Conductive	<input type="checkbox"/> Conductive	
	<input type="checkbox"/> Mixed	<input type="checkbox"/> Mixed	
	<input type="checkbox"/> Auditory Neuropathy	<input type="checkbox"/> Auditory Neuropathy	

Conductive Loss is: Intermittent Permanent Prolonged (3 months or more)

Infant has Atresia: Y N **Bilateral:** **Unilateral:** Right Left

Other diagnoses related to hearing status: _____

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

Examining Audiologist: _____

Examining Audiologist E-mail: _____

Referring Agency Name: _____

Referring Agency Phone: _____

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

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

Did parents decline referral to Parent Links? Y N

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