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 N	ame:	_						
			First		Midd	lle	Last	
Gender:	M	F	Birthda	ate:			Birth Hospital:	
Primary L	angu	age o	f the Ho	me:				
Child's P	hysica	al Add	lress:					
					Street	City	Zip	County
Mother's	(Guar	dian's	s) Name:					
Mother's	Conta	ot:			First Midd	lle	Last	
MOUTET 5	Conta		Home or	Cell	(Voice/TTY/VP)	Worl	E-mail Address	
Father's (Guard	dian's			,			
·	•		,		First Midd	lle	Last	
Father's (Conta	ct: _						
			Home or	Cell	(Voice/TTY/VP)	Worl	E-mail Address	
Mother's (If different		_			Street	City	7in	County
Father's		•			Sireet	City	Zip	County
(If different		_			Street	City	Zip	County
					Left		Right	
	He	aring	Level		Normal Slight Mild Moderate		Normal Slight Mild Moderate	
					Moderately-Severe Severe Profound		Moderately-Severe Severe Profound	Date Hearing Status
	Не	Type	of Loss		Sensorineural Conductive Mixed Auditory Neuropathy		Sensorineural Conductive Mixed Auditory Neuropathy	Identified
	s Atre	sia: es rela	1 Y	٧	Bilateral Unilater	al:	months or more) Right Left (Circle	(Circle one) one)
Was child Examinin				N	ls child	in fost	er care? Y	N
Examinin	_	_		il:				
Referring	_	-						
Referring	Agen	cy Ph	none:					
-					hearing loss?	Υ	N	
-					to Early Start?	Y	N	
ס paren	τs agr	ee to	reterral	10 P	arent Links?	Υ	N	

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