California Early Hearing Detection and Intervention Early Start Referrals

Please send to: **NewbornReferrals@leadkfamilyservices.org** · **Fax: 916-282-2440**

CA EHDI: LEAD-K™ LANGUAGE EQUALITY & ACQUISITION FOR DEAF KIDS
A PROGRAM OF NORCAL SERVICES FOR DEAF & HARD OF HEARING
Family Services

Referring Agency/Audiologist: Date:

Name: Contact:

Address:

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

Child's Name:	First	Middle	Last
Gender: M☐ F☐ NB☐	Birthdate:	Birth Hospital:	
Primary Language of the Home:		Baby was in NICU? Yes ☐ No☐	

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 ☐ No ☐

AUDIOLOGICAL INFORMATION INCLUDED WITH REFERRAL (optional):

☐ Audiology Report ☐ ABR Report ☐ Audiogram

	RIGHT EAR DB LEVEL: _____ (db)	**LEFT EAR DB LEVEL: _____ (db)**
Hearing Level	☐ Normal ☐ Slight ☐ Mild ☐ Moderate ☐ Moderately-Severe ☐ Severe ☐ Profound	☐ Normal ☐ Slight ☐ Mild ☐ Moderate ☐ Moderately-Severe ☐ Severe ☐ Profound
Type	☐ Sensorineural ☐ Conductive ☐ Permanent ☐ Prolonged(3+ months) ☐ Intermittent ☐ Mixed ☐ Auditory Neuropathy	☐ Sensorineural ☐ Conductive ☐ Permanent ☐ Prolonged(3+ months) ☐ Intermittent ☐ Mixed ☐ Auditory Neuropathy
Additional Information	☐ Atresia ☐ Bilateral ☐ Unilateral ☐ Right ☐ 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: