California Early Hearing Detection and Intervention Early Start Referrals

Please send completed form 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

Acronyms used: LEAD-K (Language Equality and Acquisition for Deaf Kids), NICU (Neonatal Intensive Care Unit), TTY (Teletypewriter), VP (Video Phone), ABR (Auditory Brainstem Response), db (Decibel), HCC (Hearing Coordination Center), LEA (Local Education Agency)

Referring Agency/Audiologist Info:	
Referring Agency/Audiologist:	
Name (First):	Name (Last):
Phone Number:	Email:
Street Address:	
City:	Zip code:
Check to acknowledge you are sending information to LEAD-K Family Services ☐	

Child Information		
Name (First):	Name (Middle):	Name (Last):
Sex Listed on Birth Certificate: M☐ F☐		
Primary Language of the Home:		Was baby in NICU? Yes☐ No☐
Date of Birth (mm/dd/yy):		Birth Hospital:

Parent/Legal Guardian Information	
Parent/Legal Guardian Name (First):	Name (Last):
Relationship to Child:	
Home or Cell Number (Voice/TTY/VP):	
Work Number:	Email:
Street Address:	
City:	Zip code:

Parent/Legal Guardian Information 2	
Parent/Legal Guardian Name (First):	Name (Last):
Relationship to Child:	
Home or Cell Number (Voice/TTY/VP):	
Work Number:	Email:
Street Address:	
City:	Zip code:

Alternate Contact (Required)	
Alternate Name (First):	Alternate name (Last):
Phone number:	Email:
Relationship to child:	Street Address:
City:	Zip code:

Does your family give permission to be contacted by a Parent Mentor through LEAD-K? Yes☐ No☐
Parent(s) informed of this referral to Early Start with hearing level/diagnosis information? Yes☐ No☐

Screening Information		
Date of Testing/Hearing Status Identified (mm/dd/yy):		
AUDIOLOGICAL INFORMATION INCLUDED WITH REFERRAL (optional):		
☐ Audiology Report ☐ ABR Report ☐ Audiogram		
RIGHT EAR DB LEVEL: _____ (db)		
Right Ear Hearing Level	☐Normal ☐Slight ☐Mild ☐Moderate ☐Moderately-Severe ☐Severe ☐Profound	
Right Ear Type	☐Sensorineural ☐Conductive ☐Permanent ☐Prolonged(3+ months) ☐Intermittent ☐Mixed ☐Auditory Neuropathy	
LEFT EAR DB LEVEL: _____ (db)		
Left Ear Hearing Level	☐Normal ☐Slight ☐Mild ☐Moderate ☐Moderately-Severe ☐Severe ☐Profound	
Left Ear Type	☐Sensorineural ☐Conductive ☐Permanent ☐Prolonged(3+ months) ☐Intermittent ☐Mixed ☐Auditory Neuropathy	
Additional Information	☐Atresia ☐Bilateral ☐Unilateral ☐Right ☐Left	Other Diagnosis (please explain):
Additional Notes:		

<u>To be filled out by LEAD-K Family Services</u>

LEAD-K Family Services:

LEA email:
HCC email:
Regional Center (if applicable):
Note to LEA, your contact for Deaf Coach services in your area is: