

# California Newborn Hearing Screening Early Start Referrals

## LEAD-K FAMILY SERVICES

[NewbornReferrals@leadkfamilyservices.org](mailto:NewbornReferrals@leadkfamilyservices.org)

Fax: 916-282-2440

Questions? Contact: Julie Rems-Smario, California Department of Education, Deaf and Hard of Hearing Unit: [JRemsSmario@cde.ca.gov](mailto:JRemsSmario@cde.ca.gov) or Phone: 510-344-6173.

Child's Name:

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle

\_\_\_\_\_  
Last

Gender:  M  F  NB

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/Guardian's Contact:

\_\_\_\_\_  
Home or Cell (Voice/TTY/VP)

\_\_\_\_\_  
Work

\_\_\_\_\_  
Email Address

Parent (Guardian) Name:

\_\_\_\_\_  
First

\_\_\_\_\_  
Last

\_\_\_\_\_  
Relationship to child

Parent/Guardian's Contact:

\_\_\_\_\_  
Home or Cell (Voice/TTY/VP)

\_\_\_\_\_  
Work

\_\_\_\_\_  
Email Address

Alternate Contact (Required):

\_\_\_\_\_  
First

\_\_\_\_\_  
Last

\_\_\_\_\_  
Relationship to child

Alternate Contact Information:

\_\_\_\_\_  
Home or Cell (Voice/TTY/VP)

\_\_\_\_\_  
Work

\_\_\_\_\_  
Email Address

Parent/Guardian's Address (If different from child)

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip

\_\_\_\_\_  
County

Child's Name:

\_\_\_\_\_

First

\_\_\_\_\_

Middle

\_\_\_\_\_

Last

Date of Testing/Hearing Status Identified (mm/dd/yy): \_\_\_\_\_

Left Ear DB Level: \_\_\_\_\_

Right Ear DB Level: \_\_\_\_\_

Hearing Level	<input type="checkbox"/> Normal <input type="checkbox"/> Slight <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately-Severe <input type="checkbox"/> Severe <input type="checkbox"/> Profound	<input type="checkbox"/> Normal <input type="checkbox"/> Slight <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately-Severe <input type="checkbox"/> Severe <input type="checkbox"/> Profound
Type	<input type="checkbox"/> Sensorineural <input type="checkbox"/> Conductive <input type="checkbox"/> Permanent <input type="checkbox"/> Prolonged (3+ months) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Neuropathy	<input type="checkbox"/> Sensorineural <input type="checkbox"/> Conductive <input type="checkbox"/> Permanent <input type="checkbox"/> Prolonged (3+ months) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Neuropathy

Additional Information

Atresia

Bilateral

Unilateral

Left

Right

NICU

Foster Care

Other Diagnoses

Additional Information

Referring Agency and/or Audiologist Name & Phone/Email: \_\_\_\_\_

Email to: [ParentLinksReferrals@leadfamilyservices.org](mailto:ParentLinksReferrals@leadfamilyservices.org)

IMPORTANT! Refer LEA:  Yes  No      Automatically refer to ParentLinks

Check if family opted out of ParentLinks

For NHSP Training contact: [TrainingRequest@leadfamilyservices.org](mailto:TrainingRequest@leadfamilyservices.org)