



**REFERRAL AND TRACKING FORM**  
**ARIZONA EARLY HEARING DETECTION AND INTERVENTION &**  
**ARIZONA STATE SCHOOLS FOR THE DEAF AND THE BLIND**  
**FLAGSTAFF**



**PLEASE FAX WITH ASSESSMENT RESULTS WITHIN 48 HOURS TO:**

**ASDB fax: 928-773-9229    phone: 928-774-0655**  
**AzEHDI fax: 602-364-1495    phone: 602-364-1409**

NAME OF CHILD:		CHILD BIRTH DATE:
DATE REFERRED:	BIRTH HOSPITAL:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MOTHER'S FULL NAME:		MOTHER BIRTHDATE:
ADDRESS WITH CITY & ZIP:		
PRIMARY PERSON TO CONTACT:		HOME PHONE:
CELL PHONE:	WORK PHONE:	HOME LANGUAGE :

**TO WHAT AGENCY OR SPECIALIST HAVE YOU REFERRED THIS CHILD?**

DDD REFERRAL MADE: YES     NO     ALREADY ENROLLED   
 CRS REFERRAL MADE: YES     NO     ALREADY ENROLLED   
 ENT REFERRAL MADE: YES     NO     ENT PROVIDER NAME: \_\_\_\_\_  
 OTHER AGENCY: \_\_\_\_\_  
 OTHER SPECIALTY: \_\_\_\_\_

**AUDIOLOGIST NAME:** \_\_\_\_\_ **DATE OF EVALUATION:** \_\_\_\_\_

- Fax to both if...
- Under 3 years of age
  - Bilateral hearing loss
  - Sensorineural or Permanent Conductive
  - Auditory Neuropathy
- Fax to AzEHDI only if...
- Over 3 years of age or
  - Unilateral
  - Ruled out Hearing Loss in a Child under 3 (normal hearing results)

**TESTING THAT DETERMINED HEARING LOSS (MARK ALL THAT APPLY)**

- |  |  |
|--|--|
| <b>ABR:</b><br><input type="checkbox"/> CLICKS<br><input type="checkbox"/> TONE BURSTS/PIPS<br><input type="checkbox"/> BONE CONDUCTION<br><input type="checkbox"/> ASSR | <b>BEHAVIORAL:</b><br><input type="checkbox"/> VRA<br><input type="checkbox"/> BOA<br><input type="checkbox"/> PLAY<br><input type="checkbox"/> CONVENTIONAL |
|--|--|

**HEARING LOSS:**     CONFIRMED     Preliminary    NEXT APPT: \_\_\_\_\_

<b>DEGREE:</b>	RIGHT	LEFT	<b>TYPE:</b>	RIGHT	LEFT
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

**AMPLIFICATION:** RIGHT  LEFT     **ANTICIPATED FITTING DATE:** \_\_\_\_\_

**OTHER DISABILITIES/CONCERNS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_