



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



PLEASE FAX WITH ASSESSMENT RESULTS WITHIN 48 HOURS TO:

ASDB fax: 602-544-1704 phone: 602-771-5200
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)

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

HEARING LOSS: CONFIRMED Preliminary NEXT APPT: _____

DEGREE:	RIGHT	LEFT	TYPE:	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: _____

