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:   □ MALE □ 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: __________________________________________________________________

AUDIOLIGIST NAME: ___________________________ DATE OF EVALUATION: ____________

TESTING THAT DETERMINED HEARING LOSS (MARK ALL THAT APPLY)
ABR:
□ C LICKS   BEHAVIORAL:
□ TONE BURSTS/ PIPS   □ VRA
□ BONE CONDUCTION   □ B O A
□ ASSR   □ P L AY

HEARING LOSS:
□ CONFIRMED □ Preliminary   NEXT APPT: ____________

DEGREE: RIGHT   LEFT TYPE: RIGHT   LEFT
□ NORMAL □ MILD □ CONDUCTIVE
□ MODERATE □ SEVERE □ PERMANENT CONDUCTIVE
□ SEVERE □ PROFOUND □ MIXED
□ PROFOUND □ NEUROPATHY

AMPLIFICATION: RIGHT □ LEFT □ ANTICIPATED FITTING DATE: ____________

OTHER DISABILITIES/ CONCERNS: _______________________________________
_____________________________________________________________________
_____________________________________________________________________

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)

Revised 8/20/09