



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:

- CLICKS
- TONE BURSTS/PIPS
- BONE CONDUCTION
- ASSR

BEHAVIORAL:

- VRA
- BOA
- PLAY
- CONVENTIONAL

HEARING LOSS:

- CONFIRMED Preliminary NEXT APPT: _____

DEGREE: RIGHT LEFT **TYPE:** RIGHT LEFT

- | | | | | | |
|--------------------------|--------------------------|----------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | NORMAL | <input type="checkbox"/> | <input type="checkbox"/> | CONDUCTIVE |
| <input type="checkbox"/> | <input type="checkbox"/> | MILD | <input type="checkbox"/> | <input type="checkbox"/> | PERMANENT CONDUCTIVE |
| <input type="checkbox"/> | <input type="checkbox"/> | MODERATE | <input type="checkbox"/> | <input type="checkbox"/> | MIXED |
| <input type="checkbox"/> | <input type="checkbox"/> | SEVERE | <input type="checkbox"/> | <input type="checkbox"/> | SENSORINEURAL |
| <input type="checkbox"/> | <input type="checkbox"/> | PROFOUND | <input type="checkbox"/> | <input type="checkbox"/> | NEUROPATHY |

AMPLIFICATION: RIGHT LEFT **ANTICIPATED FITTING DATE:** _____

OTHER DISABILITIES/CONCERNS: _____

