



## Referral for Hearing/Audiology Follow Up Services

<b>Demographics:</b>		
Child's name:	Child's DOB:	Sex:
Parent Name(s):		
Home Phone:	Other Phone:	
Address:		
City:	State:	Zip:
Family's written language:		

<b>Reason for hearing referral:</b>	
The State Early Hearing Detection and Intervention (EHDI) Office at the Iowa Department of Public Health has information that indicates the <b>child's newborn hearing screening results</b> were:	
<b>Left ear:</b>	<b>Right ear:</b>

\*Iowa law requires that hospitals notify parents in writing of their infants' newborn hearing screening results.

<b>Pre-Service Coordinator assigned:</b>		
Name:	Agency:	
Phone:	Date received by Pre-SC:	
Date of first attempt to contact family:	Date of first apt.:	Date of follow-up letter to EHDI office:
Directions to home/meeting location (if appropriate):		
School District:		

<b>Results of Referral to Follow Up Hearing Services (check all that apply):</b>	
<input type="checkbox"/> Pre-Service Coordinator could not contact family after multiple attempts (according to agency policy).	
<input type="checkbox"/> Child received hearing screening prior to contact from pre-service coordinator (Date: _____ )	
<input type="checkbox"/> Child received hearing screening following contact from pre-service coordinator (Date: _____ )	
<input type="checkbox"/> Child failed re/screening and was referred for evaluation to confirm hearing loss (Date: _____ )	
<input type="checkbox"/> Hearing loss was confirmed (Date: _____ )	
<input type="checkbox"/> Child was referred to Early ACCESS - automatically eligible for Early ACCESS due to hearing loss. (Date: _____ )	
<input type="checkbox"/> Parent declined:	
<input type="checkbox"/> Screening or Rescreening (Date: _____ )	
<input type="checkbox"/> Evaluation (Date: _____ )	
<input type="checkbox"/> Early ACCESS (Date: _____ )	
<input type="checkbox"/> Referral made to another agency (list): _____	