Community Services
CSNT
of Northeast Texas, Inc.

Head Start

"Building partnerships, changing lives"

903-756-5596

HEARING REFERRAL FORM

Date: _____

Dear Head Start Parent:

Head Start requires each student receive a hearing screen after entry to school.

Your child _____ has failed the initial hearing test and also his/her follow-up re-screen.

It is suggested that he/she needs further testing by a physician.

Please take this form with you when your child is examined and ask the physician to complete the bottom half. Return completed form to Susan Horner.

Thank you for your cooperation in this matter.

Dear Physician,

Please complete the following check list and return this form at your earliest convenience to:

Susan Horner
Head Start
Nutrition Coordinator
P. O. Box 427
Linden, Tx. 75563
Fax: 903-756-3254

I have examined_____on_____and find the following:
(patient/student name) *(date)*

[ ] A fully treatable problem
[ ] A partially treatable problem
[ ] A non-treatable problem

Hearing problem was found to be of the:
[ ] outer ear [ ] middle ear [ ] inner ear [ ] other_____

I expect that on completion of treatment there will be:
[ ] No significant hearing handicap that may interfere with learning.
[ ] A handicap that may interfere with learning.

Special
Recommendations:_____
_____

_____
Physician's signature Date