

# REFERRAL FORM

## Services for Children and Adults who are Deaf/Hard of Hearing



Date: \_\_\_\_\_ Status: New Re-Open Program: \_\_\_\_\_  
(for office use only; codes below)

Client's Name: \_\_\_\_\_  
(First and Last)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Hearing Status: Hearing / Deaf / HOH

Language: English Spanish ASL Other: \_\_\_\_\_

Technology: Hearing Aids CI None Speech: Yes No

Address: \_\_\_\_\_  
*Street Name and #, City, State, Zip*

Phone 1 (\_\_\_\_) \_\_\_\_\_ Type:  Home  Mobile/Cell  VideoPhone  Text

Phone 2 (\_\_\_\_) \_\_\_\_\_ Type:  Home  Mobile/Cell  VideoPhone  Text

Email \_\_\_\_\_ Best way to reach me: \_\_\_\_\_

How did you hear about our programs? (Please circle)

Internet Friends/Family Members FIRST 5 Community  
School Court Insurance Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance#: \_\_\_\_\_

*For children 18 and under:*

#1 Parent's/Guardian's Name: \_\_\_\_\_  
(First and Last)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Hearing Status: Hearing / Deaf / HOH

Ethnicity: Caucasian Hispanic African American Asian Other: \_\_\_\_\_

#2 Parent's/Guardian's Name: \_\_\_\_\_  
(First and Last)

<sup>3</sup> Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Hearing Status: Hearing / Deaf / HOH

Ethnicity: Caucasian Hispanic African American Asian Other: \_\_\_\_\_

Are there additional children in the family? Yes No *If yes, how many:* \_\_\_\_\_

### Send Referral Forms to:

Family & Children Services, ATTN: Evette Ybarra, ASW

Fax: (408) 287-3104; Mail: 950 W. Julian St, San Jose, CA 95126

Or call to schedule an appointment: (408) 200-8618 Voice, or (408) 899-5207 VP

OFFICE USE ONLY: Service Type: CMH: Mental Health F5: FIRST 5 HNPF: Parenting/After-School Program/KAMP