beginnings
EMPOWERING PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING THROUGH EDUCATION AND SUPPORT
guidance for your child's journey™

Phone: 919-715-4092 **Fax: 919-715-4093**

The mission of BEGINNINGS is to provide emotional, informational, and technical support to (1) parents of children, from birth through age 22, who are deaf or hard of hearing, (2) deaf parents with hearing children, and (3) professionals serving those families. BEGINNINGS believes that given accurate, objective information about hearing loss, parents are empowered to make sound decisions and to advocate for their child about educational placement, communication methodology, and related service needs.

REFERRAL TO BEGINNINGS

Parent/Guardian Name: _____

Address: _____ **Phone No.: (h)** _____

_____ **Phone No.: (w/c)** _____

County of Residence: _____ **Email Address:** _____

Referral Source Information: **Date:** _____

Name: _____ **Phone No.:** _____

Title: _____ **Fax No.:** _____

Firm Name: _____ **Email Address:** _____

Address: _____

Please fill in any necessary information BEGINNINGS may need to serve this family:

Child's Name: _____ **Child's Sex:** _____

Age of Identification: _____ **D.O.B.:** _____

Degree of Hearing Loss: _____

Pertinent Information (including language spoken in the home and ethnicity):

_____

_____

Audiologist's Name: _____

Phone No.: _____ **Fax No.:** _____

EI Service Coordinator's Name: _____

Phone No.: _____ **Fax No.:** _____

Signature of Parent/Legal Guardian: _____ **Date:** _____

By signing this Referral to BEGINNINGS, I hereby request and authorize the release or re-release of an audiological report to BEGINNINGS. I certify that this authorization is made freely, voluntarily, and without coercion. A photocopy of this authorization may be considered as valid and original.