437 Center Street, West Columbia, SC 29169
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info@scbegin.org www.scbegin.org

The mission of BEGINNINGS is to provide emotional, informational, and technical support to (1) parents of children, from birth through age 21, who are deaf or hard of hearing, (2) deaf parents with hearing children, and (3) professionals serving those families. BEGINNINGS SC 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(s)/Guardian(s) Names:

Address:

Mother: Phone #: (h) Phone #: (c) Phone #: (w)

Father: Phone #: (h) Phone #: (c) Phone #: (w)

Email Address(es): **Parents' preferred way to communicate: _____

County of Residence: **Language Spoken in the home: _____

Referral Source Information: Date:

Name: Phone No.:

Title: Fax No.:

Firm Name: Email Address:

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

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

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

Degree of Hearing Loss: _____ SS#:_____

**New Diagnosis: ___ Yes ___ No
**Most critical concern(s) at this time:

Audiologist's Name:

Phone #:_____ Fax #:

EI Service Coordinator/Teacher's Name:

Phone #:_____ Fax #:

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

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