437 Center Street, West Columbia, SC 29169
T-803.216.1171 F-803.753.0094 VP-803.929.7785
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 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.

## SELF-REFERRAL TO BEGINNINGS

**Parent/Guardian Names:** _____

**Address:** _____ **Phone #: (h)** _____

_____ **Phone #: (w/c)** _____

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

_____ ***Please fill in any necessary information BEGINNINGS may need to serve your family: **For D/HOH children, BEGINNINGS must have an audiological report on file showing hearing loss.****

**Child's Name:** _____ **Male/Female** _____

**Age when diagnosed with hearing loss:** _____ **D.O.B.:** _____

**Degree of Hearing Loss:** _____ **SS#** _____

**Language Spoken in the home:**

**Siblings:**

**School/Daycare Name:**

**Phone #:** **Teacher's Name:**

**Audiologist's Name:**

**Phone #:** _____ **Fax #:**

**Speech-Language Pathologist's Name:**

**Phone #:** _____ **Fax #:**

**EI Service Coordinator's Name:**

**Phone #:** _____ **Fax #:**

****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.***