San Francisco Unified School District
Student, Family, and Community Support Department
School Health Programs
地址：1515 Quintara St.
San Francisco, CA 94116
電話：415/242.2615
傳真： 242.2618
網址：http://www.healthiersf.org

親愛的家長/監護人:

在______________________（日期）您子女在學校獲得了聽力檢查。但他/她沒有通過今次檢查，而需接受進一步檢查。

- 請帶您子女到他/她的醫護人員處作進一步檢查。請帶上此信和附頁的報告。請叫醫護人員填寫此信的背面，並寄回上址。您子女的醫護人員可能有必要轉介您子女接受一個完整的聽力測試。如果您子女沒有自己的醫護人員，請聯繫您子女的醫療保險公司，以找到一位兒科醫護人員。

- 如果您子女沒有醫療保險，請聯繫以下任何保險公司。您也可以聯繫三藩市總醫院兒童保健中心，以尋求有關醫療保險的援助：

  - 三藩市健康計劃　電話：1-888-201-6374
  - 加州全民保健計劃 - Medi-Cal　電話：1-800-300-1506
  - 三藩市總醫院　電話：415-206-8383 (兒童保健中心)

如果有任何疑問，請與上學日健康計劃（隸屬於學生、家庭和社區支援服務部（SFCSD））的護士聯絡，電話：（415）242-2615。謝謝。

學生資料 – 用於聽力檢查

______________________ 學生姓名	______________________ 學校
______________________ 學生家庭住址	______ 年級　______ 課室號
______________________ 市/郵編	______________________ 出生日期 (月/日/年)

轉介原因：沒有通過聽力測試（請將附頁報告交予您子女的醫務人員）

Translation is provided by SFUSD Translation and Interpretation Unit.

PLEASE RETURN THIS REPORT TO ADDRESS BELOW WHEN COMPLETE

Dear Healthcare Provider:

This student is being referred to you because s/he did not pass the hearing screening at school (see attached report). Please examine the child, complete the report below, and return report to:

School Health Programs, SFCSD
Attention: Hearing Screening
1515 Quintara Street, San Francisco, CA 94116

HEALTHCARE PROVIDER REPORT   DATE OF EXAM ___/___/___

FINDINGS:

- ❑ *Passed hearing screen* ❑ *Right ear* ❑ *Left ear* ❑ *Both ears*
- ❑ *Failed hearing screen* ❑ *Right ear* ❑ *Left ear* ❑ *Both ears*
- ❑ *Abnormal middle ear exam* ❑ *Right ear* ❑ *Left ear* ❑ *Both ears*
- ❑ *Abnormal ear canal* ❑ *Right ear* ❑ *Left ear* ❑ *Both ear*
- ❑ *Right ear hearing loss* ❑ *Mild* ❑ *Moderate* ❑ *Severe* ❑ *Profound**
- ❑ *Left ear hearing loss* ❑ *Mild* ❑ *Moderate* ❑ *Severe* ❑ *Profound**

* If child fails hearing screen and has no other findings, please refer for complete audiological assessment

	250	500	1000	2000	3000	4000	8000
Right ear							
Left ear							

Recommendations:

- ❑ No treatment recommended at this time.
- ❑ Student referred for further evaluation on:___________________________________, by:____.
- ❑ Student currently receiving treatment and will receive follow-up on______________.
- ❑ Hearing aids prescribed
- ❑ Student should be referred to SFUSD Hearing Services
- ❑ Student should be referred to SFUSD Speech and Language Services
- ❑ Other____

Name of Examiner:___________________________Specialty:________________

Signature:__________________________________Date:_____________________

Address:___________________________________Phone:____________________