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

Mahal na Magulang/Tagapangalaga:

Ang isang screening sa pagdinig ay isinasagawa sa paaralan ng inyong anak noong . Ang iyong anak ay hindi pumasa sa screening sa pagdinig at kinakailangan ang karagdagang pagsusuri.

- Mangyaring patingnan ang iyong anak sa kanyang healthcare provider para sa karagdagang pagsusuri. Dalhin ang sulat na ito at ang naka-attach na report. Ipakumpleto sa healthcare provider ang nasa likod ng sulat na ito at ipadala ito sa address sa itaas. Baka kailanganing i-refer ng iyong healthcare provider ang iyong anak para sa isang kumpletong pagsusuri ng tainga at pagdinig. Kung ang iyong anak ay walang healthcare provider, makipag-ugnay sa tagabigay ng health insurance ng iyong anak upang makahanap ng isang pediatric provider.

- Kung ang iyong anak ay walang health insurance, mangyaring makipag-ugnay sa isa sa mga sumusunod na tagabigay ng insurance. Maaari ka ring makipag-ugnay sa San Francisco General Hospital Children's Health Center para matulungan sa health insurance:
  - SF Health Plan 1-888-201-6374
  - Covered CA – Medi-Cal 1-800-300-1506
  - SF General 415-206-8383 (Children's Health Center)

Kung mayroon kang mga tanong, mangyaring makipag-ugnay sa Nurse of the Day at School Health Programs, SFCSD sa (415) 242-2615. Salamat po.

IMPORMASYON NG MAG-AARAL PARA SA SCREENING SA PAGDINIG

_____ _____
Pangalan ng Mag-aaral Paaralan

_____ _____ _____
Address ng Mag-aaral Grade Room #

_____ _____
Lungsod/Zip Code Petsa ng Kapanganakan

Dahilan para sa Referral: Hindi pumasa sa screening sa pagdinig (Dalhin ang naka-attach na report sa healthcare provider)

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:_____

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