Mail: BabyTalk
Stanford Ear Institute
2452 Watson Ct, Suite 1700
Palo Alto, CA 94303
Email: BabyTalk@ohns.stanford.edu
Web: http://babytalk.stanford.edu
Phone: 650-780-1820

Thank you for applying to BabyTalk.

Please send the following documents by Mail or Email	**Circle N/A if not applicable:**
1. This application form	
2. Copy of your child's hearing test results	N/A
3. Copy of Individual Family Service Plan (IFSP)	N/A
4. Copy of any other current related reports	N/A

Child

First ____________________ Last ______________________ Girl/Boy Date of Birth: _____/_____/_____
Child lives with [ ] Mother [ ] Father [ ] Both Parents

Mother

First ____________________ Last ______________________ Phone __________________________________
Street _________________________________ Apt _________ Cell Phone _______________________________
City _____________________ State ________ Zip _________ Email __________________________________

Father

First ____________________ Last ______________________ Phone __________________________________
Street _________________________________ Apt _________ Cell Phone _______________________________
City _____________________ State ________ Zip _________ Email __________________________________

How did you find out about *BabyTalk*? ____

Which parent will participate in teletherapy? ____

Will you need an interpreter? [ ] No [ ] Yes [ ] Language ____

I want my child to communicate using
[ ] spoken language [ ] sign language only [ ] sign language and spoken language equally
[ ] other __________________________________

When was your child's hearing loss identified? (Date) _____/_____/_____

Please describe your child's hearing: *Circle all that apply for each ear. If unknown, leave blank.*

Ear	Hearing Loss	Type of Loss	Device	Device Manufacturer	Date Received
Right Ear	Mild Moderate Severe Profound	Conductive Mixed Sensorineural	None Hearing Aid Cochlear Implant Baha	______________________ ______________________ ______________________	____/____/____
Left Ear	Mild Moderate Severe Profound	Conductive Mixed Sensorineural	None Hearing Aid Cochlear Implant Baha	______________________ ______________________ ______________________	____/____/____

Audiology Services Where does your child receive services for his/her hearing devices?

Facility ____
First ____________________ Last ______________________ Phone __________________________________
Street ____ Cell Phone _______________________________
City _____________________ State ________ Zip _________ Email __________________________________

Who are the professionals working with you and your child (teachers, therapists, etc.)?

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based

Facility ____________________
First ____________ Last ____________ Phone ____________
Street ____________________ Cell Phone ____________
City ____________ State ______ Zip ______ Email ____________
[ ] Audiology [ ] Listening therapy [ ] Speech therapy [ ] Sign language development
[ ] OT/PT [ ] Sign + Speech [ ] Feeding [ ] Infant Specialist
Minutes per week: ____________ [ ] In Home [ ] Center based