# MANTECA UNIFIED SCHOOL DISTRICT

— MANTECA — LATHROP — FRENCH CAMP — WESTON RANCH —

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Manteca, CA 95337
(209) 825-3200
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**Department of Health Services**
Jessica Red, Coordinator | jred@musd.net | (209) 858-0782

## Nurse Referral Form

Please complete the top portion and submit the form to your school nurse for assessment

Student Name: ______________________ DOB: ____________ Grade: ____________

School: ______________________ School Year: ____________

School Nurse: ______________________ Date of Referral: ____________

Date Results Needed: ____________

Name of person requesting referral (**Please note**: Only Teachers, School Nurses, Parents/Guardians or Medical Providers may request referrals)

- ☐ Teacher: ____________ ☐ School Nurse: ____________
- ☐ Parent/Guardian: ____________ ☐ MD/DO/NP/PA: ____________

Assessment Type:

- ☐ Hearing ☐ Vision ☐ Health Assessment
- ☐ Health Education/Anticipatory Guidance ☐ Nutrition Assessment

Reason for referral: ______________________

______________________

Signature of person requesting referral: ______________________ Date: ____________

**For School Nurse Use Only:**

Date referral received: ____________

**Hearing Screening Results:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Otoacoustic Emission: | Right Ear: | ☐ Pass | ☐ Rescreen | ☐ Refer | ☐ Unable to screen |
| Date: | Left Ear: | ☐ Pass | ☐ Rescreen | ☐ Refer | ☐ Unable to screen |
| ☐ Audiometer: | Right Ear: | ☐ Pass | ☐ Rescreen | ☐ Refer | ☐ Unable to screen |
| Date: | Left Ear | ☐ Pass | ☐ Rescreen | ☐ Refer | ☐ Unable to screen |

| Initial/First Threshold (if needed) Date: | | | | | Second Threshold (if needed) Date: | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Freq.** | **500** | **1000** | **2000** | **4000** | **Freq.** | **500** | **1000** | **2000** | **4000** |
| **R dB** | | | | | **R dB** | | | | |
| **L dB** | | | | | **L dB** | | | | |

**Vision Screening Results:**

SPOT screener: ☐ Pass ☐ Refer ☐ Unable to Screen - see comments

Sloan Charts: ☐ Used ☐ Not used

Approx. acuity for: Near Vision: 20/____ Distance vision Right Eye: 20/____ Distance vision Left Eye: 20/____

Comments: ______________________

School Nurse Name: ______________________ School Nurse Signature: ______________________

☐ Results documented into Q ☐ Results documented into SEIS Present levels *(if needed)* ☐ Billing