

Reference Info Update

Child Last Name:		Date of Birth:		-		-	2	0	1	
Child First Name:		Sex:	M	<input type="checkbox"/>	F	<input type="checkbox"/>				
Contact Information: Please identify contact as Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Agency <input type="checkbox"/>										
Last Name:		Primary Phone Number:								
First Name:										
Address Line 1:		Alternate Phone Number:								
Address Line 2:										
City:		State:		Zip Code:						
Birth Facility Name:		PCP Group:								

Testing Information

Tester Last Name:		Title:		Test Date:		-		-	2	0	1
Clinic Name:		Clinic Number:									C
Post-Neonatal Risk Factors			Reason for Evaluation								
<input type="checkbox"/> Caregiver concerns about hearing, speech, language, or developmental delay <input type="checkbox"/> Physical finding associated with a syndrome involving hearing loss (e.g. white forelock)			<input type="checkbox"/> Neurodegenerative disorder <input type="checkbox"/> Post-natal infections (e.g. herpes, varicella, meningitis) <input type="checkbox"/> Head trauma <input type="checkbox"/> Diagnosed cytomegalovirus (CMV) <input type="checkbox"/> Chemotherapy			<input type="checkbox"/> Second opinion <input type="checkbox"/> Follow up for hearing loss <input type="checkbox"/> Other risk factors <input type="checkbox"/> Parent concern <input type="checkbox"/> Recurrent otitis media			<input type="checkbox"/> Newborn hearing screening <input type="checkbox"/> Hospital screening (AABR) <input type="checkbox"/> Hospital screening (OAE) <input type="checkbox"/> Risk factors for progressive hearing loss <input type="checkbox"/> Speech delay		

Diagnostic Test Battery

Left Ear				Right Ear			
 Tympanometry 	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Could Not Do <input type="checkbox"/> Did Not Do <input type="checkbox"/>	226 Hz <input type="checkbox"/> 660 Hz <input type="checkbox"/> 1000 Hz <input type="checkbox"/>		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Could Not Do <input type="checkbox"/> Did Not Do <input type="checkbox"/>	226 Hz <input type="checkbox"/> 660 Hz <input type="checkbox"/> 1000 Hz <input type="checkbox"/>		
 OAE DPOAE <input type="checkbox"/> TEOAE <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Could Not Do <input type="checkbox"/> Did Not Do <input type="checkbox"/>			Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Could Not Do <input type="checkbox"/> Did Not Do <input type="checkbox"/>			
 ABR Click Air <input type="checkbox"/> Click Bone <input type="checkbox"/> Toneburst <input type="checkbox"/> (NR = No Response) (NT = Not Tested)	Click Air Threshold:		dBHL	Click Air Threshold:		dBHL	
	Click Bone Threshold:		dBHL	Click Bone Threshold:		dBHL	
	Toneburst: 500Hz		dBHL	Toneburst: 500Hz		dBHL	NR <input type="checkbox"/> NT <input type="checkbox"/>
	1000Hz		dBHL	1000Hz		dBHL	NR <input type="checkbox"/> NT <input type="checkbox"/>
	2000Hz		dBHL	2000Hz		dBHL	NR <input type="checkbox"/> NT <input type="checkbox"/>
	4000Hz		dBHL	4000Hz		dBHL	NR <input type="checkbox"/> NT <input type="checkbox"/>

Behavioral Testing

Test	Interpretation of Results	Results (dBHL) per Behavioral Threshold (Hz)				Interpretation of Results
		Left Ear (or Bone Conduction, Sound Field)		Threshold	Right Ear	
<input type="checkbox"/> Air Conduction O Headphones <input type="checkbox"/> O Inserts <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Did Not Test <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/>					Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Did Not Test <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/>
<input type="checkbox"/> Bone Conduction 	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Did Not Test <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/>		dBHL	250Hz		dBHL
			dBHL	500Hz		dBHL
			dBHL	1000Hz		dBHL
			dBHL	2000Hz		dBHL
<input type="checkbox"/> Sound Field O Conditioned Play <input type="checkbox"/>	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Did Not Test <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/>		dBHL	4000Hz		dBHL
<input type="checkbox"/> SAT Threshold 			dBHL	8000Hz		dBHL
<input type="checkbox"/> SRT Threshold 			dBHL			dBHL

Diagnosis

Left Ear			Right Ear					
Diagnosis Hearing Loss	Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/>					
Degree of Hearing Loss	<input type="checkbox"/> Normal (-10--15 dBHL) <input type="checkbox"/> Slight (16--25 dBHL) <input type="checkbox"/> Mild (26--40 dBHL)	<input type="checkbox"/> Moderate (41--55 dBHL) <input type="checkbox"/> Mod Severe (56--70 dBHL)	<input type="checkbox"/> Severe (71--90 dBHL) <input type="checkbox"/> Profound (91+ dBHL)	<input type="checkbox"/> Normal (-10--15 dBHL) <input type="checkbox"/> Slight (16--25 dBHL) <input type="checkbox"/> Mild (26--40 dBHL)	<input type="checkbox"/> Moderate (41--55 dBHL) <input type="checkbox"/> Mod Severe (56--70 dBHL)	<input type="checkbox"/> Severe (71--90 dBHL) <input type="checkbox"/> Profound (91+ dBHL)		
Classification of Hearing Loss	Conductive--Fluctuating <input type="checkbox"/> Mixed <input type="checkbox"/>	Conductive--Permanent <input type="checkbox"/> Neural <input type="checkbox"/>	Conductive--Undetermined <input type="checkbox"/> Sensorineural <input type="checkbox"/>	Conductive--Fluctuating <input type="checkbox"/> Mixed <input type="checkbox"/>	Conductive--Permanent <input type="checkbox"/> Neural <input type="checkbox"/>	Conductive--Undetermined <input type="checkbox"/> Sensorineural <input type="checkbox"/>		
Evaluation Status	Completed <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/> Previously Passed <input type="checkbox"/>		Completed <input type="checkbox"/> Could Not Test <input type="checkbox"/> Inconclusive <input type="checkbox"/> Previously Passed <input type="checkbox"/>					
Amplification	Hearing Aids: Y <input type="checkbox"/> N <input type="checkbox"/> Pending <input type="checkbox"/>	Asst. Devices: Y <input type="checkbox"/> N <input type="checkbox"/> Pending <input type="checkbox"/>	Cochlear Implants: Y <input type="checkbox"/> N <input type="checkbox"/> Pending <input type="checkbox"/>					
Diagnostic Report	Given/Sent to Parent <input type="checkbox"/> Sent to PCP <input type="checkbox"/>	Date:			-	2	0	1

Recommendations and Referrals

<input type="checkbox"/> Further Diagnostic Testing Appt.	<input type="checkbox"/> ENT Referral	<input type="checkbox"/> Discharged	<input type="checkbox"/> Speech/Language Referral	<input type="checkbox"/> Genetics Referral
<input type="checkbox"/> Further Diagnostic Testing Referral	<input type="checkbox"/> Medical Exam Referral	<input type="checkbox"/> Hearing Aid Evaluation	<input type="checkbox"/> Vision Referral	<input type="checkbox"/> Early Intervention Referral
Appt Scheduled with		Date: ___/___/___	Time: ___:___ am pm	