Pediatric Hearing Screening Results Form

Directions: Use this form for early childhood or school-aged hearing screenings. Provide caregiver/s with a copy of this form, and keep a copy for your records.

PATIENT INFORMATION:			
Child Name: (Last)	**Child Name:** (First)	**Date of Birth:** / /	**Date of Screening:** / /
Sex: □ Male □ Female	**Primary Language:** □ English □ Other _____	**Child's School Name:** (If applicable)	
Parent/Guardian Name: (Last)	**Parent/Guardian Name:** (First)	**Phone Number:**	

Select One: ☐ Initial hearing screen ☐ Final hearing screen

Note: A second/final hearing screen is not required, but if completed, should be completed 2 weeks following the failed initial hearing screen.

PURE TONE SCREENING

This is the primary method of hearing screening.

RESULTS (If applicable):

Mark a "P" for "Pass" and "F" for "Fail" for each frequency tested. A Fail at any one frequency for either ear results in a Fail result for the screen. If unable to screen, write "CNT" (Could Not Test) and provide justification in the notes section below.

	500 Hz	**1000 Hz**	**2000 Hz**	**4000 Hz**
Right Ear				
Left Ear				

AUTOMATED OTOACOUSTIC EMISSIONS (AOAE)

AOAEs should only be completed if the child is developmentally unable to complete pure tone screening.

RESULTS (If applicable):

A "Fail" for either ear results in a fail result for the screen.

	Pass	**Fail**
Right Ear		
Left Ear		

RESULTS AND RECOMMENDATIONS:

☐**Passed hearing screen for both ears.** Follow-up with primary care physician if concerns of speech and/or hearing arise.
Select type of test used below.
- ☐ OAE *(if selected, provide comments below explaining why pure tone screening could not be completed.)*
- ☐ Pure Tone Screening

☐**Failed hearing screen.** *Select all that apply.*
- ☐ Return in two weeks to rescreen hearing.
- ☐ Child should be seen by a pediatric audiologist for a hearing evaluation as soon as possible.
- ☐ Child should be seen by primary care physician for medical evaluation.

☐**Did Not Test/Could Not Complete.** *(If checked, select reason below)*
- ☐ Child is unable to complete task due to developmental level
- ☐ Child is averse to wearing headphones
- ☐ Could not maintain seal to complete screen
- ☐ Child is averse to tip placement
- ☐ Other (must explain): _____

NOTES/COMMENTS:

Screener's Name (Please print):	**Screener's Title:**	**Date of Screening:**

Screener's Signature: _____

By signing, I certify that the child has received the hearing screen, and the results are accurate to the best of my knowledge.