



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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> 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				AUTOMATED OTOACOUSTIC EMISSIONS (AOAE)			
<i>This is the <u>primary method</u> of hearing screening.</i>				<i>AOAEs should <u>only</u> be completed if the child is developmentally unable to complete pure tone screening.</i>			
RESULTS (If applicable): <i>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.</i>				RESULTS (If applicable): <i>A "Fail" for either ear results in a fail result for the screen.</i>			
	500 Hz	1000 Hz	2000 Hz	4000 Hz		Pass	Fail
Right Ear					Right Ear		
Left 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): _____



Scan to find a pediatric audiologist

NOTES/COMMENTS:

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