

State of Connecticut
 Department of Public Health
 Early Hearing Detection and Intervention
 DIAGNOSTIC AUDIOLOGY REPORTING FORM

Child's Last Name First Name DOB Birth Hospital Accession Number

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Parent / Responsible Party Name Parent/ Responsible Party Address Parent/ Responsible Party Telephone

Pediatrician Name Address Telephone

Date of Evaluation: _____

Did not Keep Appointment: _____

Purpose of Appointment: INITIAL SCREEN Screening Method: OAE / ABR Results RIGHT: PASS / REFER
 RESCREEN Results LEFT: PASS / REFER
 DIAGNOSTIC TESTING FOLLOW UP TESTING

DIAGNOSTIC ABR RESULTS:

	Right Ear	Left Ear
Hearing within Normal Limits.....	<input type="checkbox"/>	<input type="checkbox"/>
TYPE OF HEARING LOSS:		
Sensorineural Hearing Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Conductive Hearing Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Mixed Hearing Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Undetermined Type Hearing Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
DEGREE OF HEARING LOSS: (Degree of AC Thresholds at 500, 1000, 2000 Hz)		
Mild Hearing Loss (26-40 dB HL).....	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Hearing Loss (41-60 dB HL).....	<input type="checkbox"/>	<input type="checkbox"/>
Severe Hearing Loss (61-80 dB HL).....	<input type="checkbox"/>	<input type="checkbox"/>
Profound Hearing Loss (80+ dB HL).....	<input type="checkbox"/>	<input type="checkbox"/>

Other Tests Conducted (Please Specify): _____

Was this a Progressive or Late Onset Hearing Loss? Yes No Unknown

Hearing Aid Candidate? Yes No Not Determined Date of Amplification: _____

Cochlear Implant Candidate? Yes No Not Determined Date of Implant if Known (mm/yy): _____

Referred for Genetic Testing? Yes No Unknown

CHILD DEV INFOLINE CONTACTED? Yes Date: _____ **LISTEN & LEARN CANDIDATE?** Yes
 (Referral Line: 800-505-7000) No Reason: _____ No

RISK FACTORS: (Check all that Apply)

- | | |
|---|---|
| <input type="checkbox"/> None Known
<input type="checkbox"/> Family History
<input type="checkbox"/> Medical Cond. Assoc. w/loss
<input type="checkbox"/> Meningitis
<input type="checkbox"/> Mechanical ventilation > 5 days
<input type="checkbox"/> Ototoxic Meds | <input type="checkbox"/> Hyperbilirubinemia with Exchange Transfusion
<input type="checkbox"/> In Utero Infection
<input type="checkbox"/> Craniofacial Anomalies
<input type="checkbox"/> Low Birth Weight (less than 3.3 lbs)
<input type="checkbox"/> Other Stigmata Specify: _____ |
|---|---|

AUDIOLOGIST'S RECOMMENDATIONS:

ENT REFERRAL? Yes No Referred to: _____ Telephone: _____

TESTING CONDUCTED BY: _____
 NAME OF CENTER: _____ TELEPHONE: _____