HEARING SCREENING REPORT

Name: _____ D.O.B.: _____
Location of Screening: _____ Date of Test: _____
Tested by _____

1. VISUAL INSPECTION

Does child have ventilation tubes? ☐ Yes ☐ No
If yes, indicate which ear(s) ☐ Right ☐ Left **Check One**: ☐ Pass ☐ Refer
Comments:

2. TYMPANOMETRY/IMPEDANCE SCREENING

	Physical Volume	Compliance	Tube Patent	Comments
Right Ear			☐ Yes ☐ No ☐ NA	
Left Ear			☐ Yes ☐ No ☐ NA	

Check One: ☐ Pass
☐ Refer

3. OTOACOUSTIC EMISSIONS SCREENING (1500-8000 Hz) OAE

Check One: ☐ Pass Date: _____
☐ Refer Screened By: _____

4. PURE TONE THRESHOLD SCREENING

	500HZ	1000Hz	2000Hz	4000Hz		500Hz	1000Hz	2000Hz	4000Hz
RE					LE				

Check One: ☐ Pass Date: _____
☐ Refer Screened By: _____

RECOMMENDATIONS:

☐ Pass ☐ Rescreen in about 1 month ☐ Medical Referral ☐ Medical & Audiological Referral

☐ Audiological Referral for complete hearing evaluation

Comments: