APPENDIX A

FORMS

HEARING SCREENING REPORT

Name: ______________________________ D.O.B.: __________

Location of Screening: ______________________________

SWEEP FREQUENCY SCREENING

Check (✓) One: ☐Pass ☐Rescreen

Date: __________

Screened By: __________

SWEEP FREQUENCY RESCREENING

Check (✓) One: ☐Pass ☐Rescreen with threshold screen

Date: __________

Screened By: __________

THRESHOLD SCREENING

RE	500 Hz	1000 Hz	2000 Hz	4000 Hz	6000 Hz	LE	500 Hz	1000 Hz	2000 Hz	4000 Hz	6000 Hz

Check (✓) One: ☐ Pass ☐ Refer ☐ Does not meet referral criteria. Rescreen in one year

Date: __________

Screened By: __________

VISUAL INSPECTION

Does child have ventilation tubes? ☐Yes ☐No

If yes, indicate which ear(s) ☐Right ☐Left

Comments:

Check (✓) One: ☐Pass ☐Refer

Date: __________

Screened By: __________

TYMPANOMETRY SCREENING

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

Check (✓) One: ☐Pass ☐Refer

Date: __________

Screened By: __________

RECOMMENDATIONS

Check (✓) One:

☐ Pass ☐ Rescreen in 2 to 4 weeks ☐ Medical Referral & Rescreen ☐ Medical & Audiological Referral ☐ Audiological Referral

Comments:

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