Print Form

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**

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** **Results RIGHT:** ☐ **PASS** ☐ **REFER**

RESCREEN ☐ ☐ **ABR** **Results LEFT:** ☐ **PASS** ☐ **REFER**

DIAGNOSTIC TESTING ☐ **FOLLOW UP TESTING** ☐ **RISK FACTOR MONITORING** ☐

DIAGNOSTIC ABR RESULTS: **Right Ear** **Left Ear**

Hearing within Normal Limits (-10 to 15 dB HL)	☐	☐
TYPE OF HEARING LOSS:		
Sensorineural Hearing Loss	☐	☐
Conductive Hearing Loss	☐	☐
Mixed Hearing Loss	☐	☐
Undetermined Type Hearing Loss	☐	☐
DEGREE OF HEARING LOSS: (Degree of AC Thresholds at 500, 1000, 2000 Hz)		
Slight (16 to 25 dB HL)	☐	☐
Mild (26 to 40 dB HL)	☐	☐
Moderate (41 to 55 dB HL)	☐	☐
Moderately severe (56 to 70 dB HL)	☐	☐
Severe (71-90 dB HL)	☐	☐
Profound (91+ dB HL)	☐	☐

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** ☐

Referred to Birth to Three? **Yes** ☐ Date: _____

(Referral Line: 800-505-7000) **No** ☐ Reason: _____

RISK FACTORS: (Check all that Apply)

- ☐ **None Known**
- ☐ **Culture Positive Postnatal Infections**
- ☐ **Hyperbilirubinemia**
- ☐ **NICU Care >5 days**
- ☐ **Syndromes – Specify:** _____
- ☐ **Caregiver Concern**
- ☐ **Family History**
- ☐ **In-utero Infections**
- ☐ **Ototoxic medications**
- ☐ **Craniofacial Anomalies**
- ☐ **Head Trauma**
- ☐ **Neurogenerative Disorder**
- ☐ **Physical Findings**

AUDIOLOGIST'S RECOMMENDATIONS:

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

_____

_____

TESTING CONDUCTED BY: _____

NAME OF CENTER: _____ **TELEPHONE:** _____

FAX RESULTS TO: Connecticut Dept. of Public Health, Early Hearing Detection & Intervention Program: (860) 509-8132

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