Hearing Screening Referral

Name of Pupil School Grade Age

Name & Address of Parent/Guardian Date

Parent: Your child had some difficulty with a recent school hearing screening and should be examined by an ear specialist (ENT Specialist or Audiologist) of your choice.

Reason for Referral Failed Hearing Screening at the following frequencies:

	1000	2000	4000	500
Right	____	____	____	____
Left	____	____	____	____

Referred by:_____

Please ask that this form be completed and mailed to the address in the lower left corner.

Hearing Examination Report

Referred for Treatment: Yes____ No____ If yes, nature of treatment _____

Use of Aids: Yes____ No____ If yes, _____Binaural ____Monaural

Comments or Recommendations: _____

(Attach audiogram if available)

Please check the appropriate statement based on your professional diagnosis.

___Although a hearing impairment exists, this impairment has been corrected to the extent possible and should not interfere with individual intellectual, academic, and speech/language evaluation.

___This child is experiencing a hearing impairment to the degree that he/she would require specialized evaluation. This specialized evaluation should include _____.

___Although a hearing impairment exists, it has been corrected with an aid(s) and should not interfere with intellectual, academic, and speech/language evaluation when wearing the aid(s).

___This child is not experiencing any hearing impairment that might interfere with individual intellectual, academic, and speech/language evaluation.

Date of this examination:_____ Date of next examination:_____

RETURN TO:

_____ _____

Examiner's Name Degree

_____ _____

Address

_____ _____

08/2012