Hearing Screening Referral Letter

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Child's Name: _____ Date of Birth: _____

Dear Parent(s)/Guardian(s):

Your child was given hearing screenings recently. The results of these screenings indicate that a more thorough evaluation is necessary. Your child needs to be seen by their Health Care Provider for an examination as soon as possible. Please give this form to your Provider to complete and return to our program.

_____ Address: _____

Early Learning Staff

_____

Early Learning Screening Results

	Date	L	R
Audiometer			
OAE #1			

Observations:

- ☐ Speech and Language delay noted
- ☐ Speech and Language evaluated by School District
- ☐ Behavior (List Developmental Results)

Health Care Provider Evaluation

Did the child have a cold or upper respiratory infection at today's exam? ☐ Yes ☐ No

To your knowledge, has the child been seen for treatment of ear problems more than 5 times? ☐ Yes ☐ No

Has the child experienced:

Tonsil/Adenoid removal? ☐ Yes ☐ No

Excessive Cerumen? ☐ Yes ☐ No

Related allergies? ☐ Yes ☐ No

Has the child ever had ventilation tubes? ☐ Yes ☐ No Number of times? 1 2 3+

Comments on history:

Findings

Hearing	Middle Ear Infection	Treatment
☐ Child unable to cooperate	☐ No pathology	☐ Observation
☐ Hearing check only by normal response to voice	☐ Eustachian tube dysfunction	☐ Antibiotic (Rx)
☐ Hearing loss identified by audiometric test	☐ Middle ear fluid	☐ Decongestant/Antihistamine (Rx)
☐ Audiogram attached	☐ Middle ear infection	☐ To insert tube(s)
	☐ Hole in eardrum(s)	☐ To remove adenoids
	☐ Excessive cerumen	☐ To remove tonsils

Health Care Provider follow-up: _____ weeks/months/PRN

Referred to: _____

Health Care Provider's Name: _____ Date of Exam: _____

Please fill out this form and return to parent/guardian, or address above. Please note if further assessment by an audiologist is recommended (see back of form).

Child's Name: _____ Date of birth: _____

Early Learning Inner Ear Screening

OAE 2 Rescreen (by Early Learning)

	Date	L	R
OAE #2			

Pediatric Audiological Evaluation

Date: _____ Name of person performing service: _____

Phone: _____

Audiological services performed: ☐ ABR ☐ Behavioral ☐ Other

Hearing Status: (check one box under Type and Degree for each ear)

Ear	L	R	Type of loss	Ear	L	R	Degree of Loss
	☐	☐	Permanent loss (sensorineural, conductive, mixed)		☐	☐	Mild
					☐	☐	Moderate
	☐	☐	Temporary loss (fluctuating conductive)		☐	☐	Severe
					☐	☐	Profound
	☐	☐	Normal – no loss		☐	☐	Normal – no loss

Follow-up recommendation(s) and date by which recommendation should be completed: (check all that apply)

☐ None

☐ Repeat hearing screening (___/___/___)

☐ Further medical evaluation (___/___/___)
☐ ABR ☐ Behavioral

☐ Referral to Early Intervention (___/___/___)

☐ Other _____ (___/___/___)

Please complete evaluation and return to Parent/Guardian, or send this form to address below:

Name: _____

Title: _____

Early Learning Center Address:

_____

_____

_____