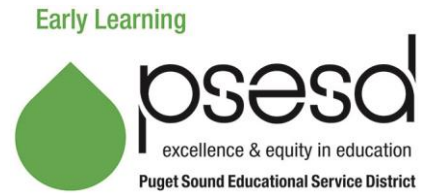


Vision and Hearing Screening Summary (0-3 Years)



Child's Name: _____

Birthdate: _____

Family Educator/Advocate: _____

I. Parent/Caregiver Interview

What concerns do you have about your child's hearing and vision? (Describe in Detail):

I have no concerns at this time. (Parent Initials): _____

II. Developmental Skills Checklist

(describe any identified skills of concern for child's age)

Vision Related

Hearing Related

Hearing Screening Using OAE Machine

Results of Newborn hearing screening

Pass Refer

Results of first OAE Hearing Screening Date _____

Pass Rescreen L R Refer

If screening is a Rescreen or Refer do 2nd OAE

Results of OAE Hearing Rescreen Date _____

Pass Rescreen L R Refer

If child does not pass refer parent to Primary Care Provider

Results of OAE Rescreen (after medical clearance) Date _____

Pass Refer

If child does not pass refer to Audiologist

III. Observations

(describe parent/staff observations that might indicate higher risk for vision/hearing problems)

Vision Screening Using Spot Screener

Results of Infant SEE evaluation (between 6-12 months)

Pass Refer Comments: _____

Results of first Spot Screening Date _____

Pass Refer

Parent/Caregiver _____

Date _____

Family Educator/Advocate _____

Date _____

Copy to: PCP, parent, file



Revised 09/2017

Page 1 of 1

12.011.10 CPolasek