

OAE Hearing Screening Form



Program _____ Child's Name _____

Child Information	Child's ID #: _____	Date of Birth: (__/__/__)
	<input type="checkbox"/> Male <input type="checkbox"/> Female Screened for hearing loss at birth? <input type="checkbox"/> Unknown <input type="checkbox"/> Not screened <input type="checkbox"/> Passed <input type="checkbox"/> Referred	

Hearing Screening Outcomes	Screeener's Name: _____
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Child's LEFT Ear

Visual Inspection

- Refer — Date (__/__/__) → Consult health care provider; conduct OAE screening after medical clearance
- Pass

1st OAE (__/__/__) 2nd OAE (__/__/__)

- Can't test _____
- Refer _____
- Pass _____

- Can't test* _____
- Refer _____
- Pass _____

Schedule follow-up (__/__/__)

Middle Ear Consultation

(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)



Notes:

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed

Child's RIGHT Ear

Visual Inspection

- Refer — Date (__/__/__) → Consult health care provider; conduct OAE screening after medical clearance
- Pass

1st OAE (__/__/__) 2nd OAE (__/__/__)

- Can't test _____
- Refer _____
- Pass _____

- Can't test* _____
- Refer _____
- Pass _____

Schedule follow-up (__/__/__)

Middle Ear Consultation

(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)



Notes:

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed

Time Data	Approximate total time with child required for screening (in minutes):	
	1 st OAE _____	2 nd OAE _____