

Diagnostic Follow-up Form (referral from OAE hearing screening)

Early Learning



Child's Name _____



Middle Ear Consultation (typically conducted by a health care provider)

Date: (___/___/___) MD Name of person performing service: _____

Medical service(s) performed:

Otoscopy Pneumatic Otoscopy Tympanometry Other _____

Diagnosis & Treatment:

Ear L R

- Normal (no condition or disorder detected)
- Cerumen removal
- PE tube blockage cleared
- Middle ear disorder (describe):

- Other: _____

Follow-up recommendation(s) and date by which recommendation should be completed:

(check all that apply)

- None
- Repeat hearing screening (___/___/___)
- Audiological evaluation (___/___/___)
- Further medical evaluation (___/___/___)
- Referral to Early Intervention (___/___/___)
- Medical treatment (___/___/___)
- Other _____ (___/___/___)

when medical clearance is given (outer and middle ear are clear)

Inner Ear Outcome



OAE Rescreen
(by program)

Ear L R (___/___/___)

- Can't test
- Refer
-
- Pass

**Pass on both ears
Screening
Completed**



Audiological Evaluation (by pediatric audiologist)

Date: (___/___/___) Name of person performing service: _____

Audiological services performed: ABR Behavioral Other _____

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

Ear L R **Type of loss**

- Permanent loss
(sensorineural, conductive, mixed)
- Temporary loss
(fluctuating conductive)
- Normal—no loss

Ear L R **Degree of Loss**

- Mild
- Moderate
- Severe
- Profound
- 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 as soon as possible and send this form to:

Name: _____

Address: _____

Title: _____