WISCONSIN SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY ASSOCIATION, INC.
Dedicated to Helping Persons with Communicative Disorders

IMPORTANT!

Dear Colleague:

This survey has been a collaborative effort between the Wisconsin Association for Perinatal Care (WAPC), Wisconsin Speech Hearing Association (WSHA), and Wisconsin Sound Beginnings. We are in need of input from audiologists so that we may better facilitate the linkages between screening services, diagnostic services and intervention services.

The purpose of the enclosed survey is to assess the present level of participation of audiologists in newborn hearing screening. We would also like to determine the technical assistance needs of audiologists regarding all levels of diagnostics and intervention, so that we might tailor future training sessions to these needs.

The Joint Committee on Infant Hearing recommends that infants who are referred from the hearing screening are seen by an audiologist for diagnostic testing before 3 months of age. Because we want to help families through the process smoothly and efficiently, we are compiling a list of audiologists who have the knowledge, experience and equipment to work with young infants. This list will be distributed to hospitals so that they can make an initial referral to appropriate audiologists in their community. **If you want to be included on this list you must complete and return this survey!**

Your responses to the survey will be kept confidential. However, if you choose to be included on the referral list under Section V of the survey, your name, address, and phone number will be made available to the public. Please fill this survey out as an individual, **NOT** as a collective facility.

The results of this survey will help direct various aspects of the universal newborn hearing screening initiative in the state of Wisconsin. Because the completeness of the results of our findings is dependent upon the return of all surveys, **your response to the survey is vital!** The questionnaire is designed to be easily filled out in about fifteen to twenty minutes.

Please complete and return the survey in the postage-paid envelope or fax it to Elizabeth Wussow at (608) 267-9191 by October 10, 2001. Thank you in advance for your participation in this important survey. Your individual input is needed and appreciated.

Sincerely,

Elizabeth Wussow, MA, CCC-A
Wisconsin Sound Beginnings Program Director

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WISCONSIN SURVEY ON PEDIATRIC AUDIOLOGY SERVICES: AUDIOLOGIC ASSESSMENT AND AMPLIFICATION FITTING FOR CHILDREN BIRTH TO 18 MONTHS

SECTION I - General Information

Agency or Facility: _____

Contact Person: _____

Title of Contact Person: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number, including area code: (___) _____

Fax Number, including area code: (___) _____

Email Address: _____

1. **Are you interested in receiving referrals from a newborn hearing screening program and would you like to be included on a diagnostic referral list of providers.**

   _____INTERESTED _____NOT INTERESTED

2. **Are you interested in receiving training in order to provide comprehensive services to infants? (**Please check all that apply)

   _____No, I am not interested in receiving training at this time.
   _____Yes, I am interested in receiving training in the following areas:
   - _____Immittance audiometry
   - _____Auditory Brainstem Response
   - _____Otoacoustic Emissions
   - _____Amplification Selection Techniques
   - _____Amplification Verification Techniques
   - _____Other, describe _____

3. **May we contact you regarding future training sessions in your area?**

   _____ Yes _____ No

4. **Does your facility currently provide diagnostic audiologic services for infants birth to 18 months of age?**

   _____ Yes _____ No (If "no", please proceed to question #12)

SECTION II - Diagnostic Evaluation

5. **Please estimate the total number of babies *referred* to you from a newborn hearing screening program, in the last 12 months?**

   Total babies referred? _____ Referred prior to one month of age? _____

6. **Estimate the average age of infants referred from newborn hearing screening programs at the initial diagnostic evaluation in your facility. Check *one* of the following:**

   _____ < 3 months
   _____ 3-6 months
   _____ 7-12 months
   _____ 13-18 months

7. **The Joint Committee on Infant Hearing recommends that the following tests are conducted for a complete diagnostic audiologic evaluation. Please indicate whether you have the equipment necessary to perform each of the tests listed below. If so, approximate how many times you have performed each test in the past six months for each age group**.

Please indicate the number of times you have performed the test in the past **6 months** for each age group.						
a)	Type of Equipment	Have Equipment (yes/no)	< 3 mos.	3-6 mos.	7-12 mos.	13-18 mos.
b)	Auditory Brainstem Response(ABR) Click Stimulus					
c)	ABR Tone pip Stimulus					
d)	ABR Bone Conduction					
e)	Tympanometry (660Hz or 1000Hz)					
f)	Otoacoustic Emissions					
g)	Visual Reinforcement Audiometry					
h)	Behavioral Observation Audiometry					

8. **Does your facility have the necessary equipment and medical staff if sedation for an ABR is required?**

   _____ Yes _____ No

9. **Has your facility *confirmed* a hearing loss in at least one infant between the ages of 0 and 18 months, in the last year?**

   _____ Yes _____ No: *If "no", proceed to question 12*

10. **Please estimate the number of infants you have *confirmed* with hearing loss in the last six months in each of the following age categories.**

    _____ < 3 months
    _____ 3-6 months
    _____ 7-12 months
    _____ 13-18 months

11. **Please estimate the average age at which babies referred from newborn hearing screening programs are *confirmed* with permanent hearing loss at your facility. Check *one* of the following.**

    _____ < 3 months
    _____ 3-6 months
    _____ 7-12 months
    _____ 13-18 months

SECTION III - Amplification Services

12. **Do you offer comprehensive *amplification fitting* services for children 0-18 months at your facility?** _____ Yes _____ No

13. **Are you interested in receiving training in order to provide comprehensive amplification services to infants?**

    _____No, I am not interested in receiving training at this time. (*If you answered "no" to question 12 and 13, please proceed to question # 20)*

    _____Yes, I am interested in receiving training in the following areas.

(Please check all that apply.)

_____sound field testing using calibrated signals
_____functional gain measures (speech and/or frequency specific stimuli)
_____probe microphone testing
_____coupler testing using real-ear to coupler correction
_____informal behavioral observation
_____hearing aid selection for infants
_____FM and other listening devices
_____cochlear implant candidacy requirements
_____other, please describe _____

14. Approximately how many children has your facility *fit with amplification* in the past six months for each of the following age groups?

_____ < 3 months
_____ 3-6 months
_____ 7-12 months
_____ 13-18 months

15. Please estimate the average age at which babies referred from newborn hearing screening programs are initially fit with amplification at your facility. Check *one* of the following.

_____ < 3 months
_____ 3-6 months
_____ 7-12 months
_____ 13-18 months

16. Please indicate whether you have the equipment and knowledge necessary to perform each of the tests listed below on an infant 0-18 months of age. If so, indicate how many times you have performed each test in the past six months for each age group listed.

Please indicate the number of times you have performed the test in the past **6 months** for each age group.							
	Fitting procedure	Equipment (yes/no)	Knowledge (yes/no)	0-4 mos.	4-8 mos.	8-12 mos.	12-18 mos.
a)	Sound field testing using calibrated signals						
b)	Functional gain for speech (aided/unaided)						
c)	Functional gain for frequency specific stimuli (aided/unaided)						
d)	Probe microphone testing						
e)	Coupler testing using real-ear to coupler correction						
f)	Informal behavioral observation						
g)	Other, describe:						
h)	Other, describe:						

17. Would you be interested in providing training to colleagues in using the above procedures with children 0-18 months?

_____Yes: *If "yes" circle applicable procedures.* *a b c d e f g h*
_____No

18. Estimate the average time interval between confirmation of hearing loss and fitting of amplification for infants.

_____less than one month between confirmation and fitting
_____1-2 months between confirmation and fitting
_____2-3 months between confirmation and fitting
_____4-6 months between confirmation and fitting
_____greater than 6 months between confirmation and fitting

19. If there is greater than one month between confirmation of hearing loss and fitting of amplification, identify the issues that contribute to the amount of time that elapses.

_____funding for amplification
_____parent follow-up
_____delayed physician referral
_____incomplete diagnostic information
_____inconclusive diagnostic information
_____complicating health issues
_____other, please describe _____

SECTION IV - Post Diagnostic Protocol

20. Do you use a protocol for reporting confirmed hearing loss in infants and referring on to intervention services?

_____ Yes _____ No

21. Who do you send the report to? (check all that apply)

_____ referring source
_____ primary care physician
_____ Birth - 3 Program
_____ private therapist (OT, PT, SLP, etc.)
_____ otolaryngologist
_____ parent or caregiver
_____ other, please describe _____

22. Do you track information on the number of cases of suspected and confirmed hearing loss in infants referred from newborn screening programs?

_____ no internal tracking method is used outside of the infant's medical record
_____ a manual tracking system is used
_____ a computerized tracking system is used
_____ other, please describe _____

23. Which of the following tracking methods do you think would work well in Wisconsin to better understand the incidence of suspected and confirmed hearing loss in infants referred from newborn screening programs? (check all that apply)

_____ File a "confirmation of hearing loss" report with a state agency
_____ Use a manual carbon paper reporting system
_____ Use a web-based reporting system
_____ Other, please describe _____
_____

24. Does your facility have Internet access available for your use?

_____ Yes _____ No

25. Where does your facility refer families and infants 0-18 months of age with a confirmed hearing loss? (please check all that apply.)

_____otolaryngologist
_____Birth - 3 Program
_____local support group
_____geneticist
_____Bureau for Deaf and Hard of Hearing
_____local school district
_____regional Children with Special Health Care Needs Center
_____local public health department
_____other, please describe _____

SECTION V - Interest

26. Are you interested in having your facility included on a referral list, which will be available on the Internet as well as distributed to all hospital programs involved in universal newborn hearing screening?

_____ Yes _____ No

27. If yes, please check the category in which you feel you fit the best.

_____ Can provide *complete* screening, diagnostic, and hearing aid services for infants *0-18 months of age,* who require additional testing following newborn infant hearing screening.
_____ Can provide *some, but not all* screening, diagnostic, and hearing aid services for infants *0-18 months of age*, who require additional testing following newborn infant hearing screening.
_____ Can provide *complete* screening, diagnostic, and hearing aid services for *infants 6 months of age and up*, who require additional testing following newborn infant hearing screening.
_____ Can provide *some, but not all* screening, diagnostic, and hearing aid services for infants *6 months of age and up*, who require additional testing following newborn infant hearing screening.
_____ Can provide comprehensive hearing aid services only, to *infants 0-18 months* of age.

27. Comments: _____
_____
_____
_____
_____
_____

REFERRAL ADDRESS as you would like it listed.

Name of facility: _____

Address: _____
Street City State Zip

Phone Number: (____)_____

Thank you for taking the time to fill out this very important survey. Please return the questionnaire in the postage-paid envelope provided, or you may fax it to Elizabeth Wussow at (608) 267-3824 by April 26, 2001. If you have questions, you may call Elizabeth at (608) 267-9191.