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

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: _____ _____