AUDIOLOGIST SURVEY

1. EQUIPMENT AND FACILITY

A. Please place a check on each of the equipment/procedural items below which you have available to you for audiologic diagnostic evaluation of newborns, infants and toddlers:

__ Auditory Brainstem Response (ABR), Click Stimulus, Threshold testing capability

__ Visual Reinforcement Audiometry (VRA)

__ Transient (click) Evoked Otoacoustic Emissions (TEOAE)

__ Distortion Product Otoacoustic Emissions (DPOAE)

__ Multi-frequency Tympanometry

__ ABR Tone pip stimulus

__ ABR Bone Conduction

__ Play Audiometry

B. Please check up to two (2) items below that best describe(s) the facility(s) that you work in and also if the facility(s) has/have the capability of using sedation for testing infants and toddlers when necessary for ABR/OAE.

FACILITY	**SEDATION** YES	NO
__ Hospital, in/out patient facility	__	__
__ Clinic, outpatient (i.e.; ENT office)	__	__
__ Private practice, freestanding clinic	__	__
__ University clinic	__	__
__ Public Schools	__	__
__ Government facility (VA Hosp.)	__	__
__ State Gov't facility (A/CDC, Health Dept)	__	__
__ Other (Please name)_____		
_____	__	__

2. If you have no interest in having babies who do not pass a newborn hearing screening referred to you for diagnostic evaluation, please indicate below by checking "not interested" and go to item #6 at the end of the questionnaire. However, if you are interested in getting these types of referrals but feel you need more information about testing newborns, or would like to be informed of regional seminars and/or be sent literature containing such information, please check "interested" and continue the questionnaire.

__ INTERESTED __ NOT INTERESTED

3. Diagnostic audiologic evaluations of newborns, infants and toddlers require not only specialized equipment, but experience and interest as well. Please indicate below whether you have each piece of equipment, and if so, the number of times which you have used the equipment while seeing patients in the three age categories listed below within the last two years.

Equipment	**Have Equipment**	**Age of Infant**		
	Yes/No (Circle One)	0 12 months	13 24 months	25 36 months
ABR, Click Stimulus	Y N			
ABR, Tone Pip Stimulus	Y N			
ABR, Bone Conduction	Y N			
Visual Reinfor. Aud	Y N			
Play Audiometry	Y N			
Transient OAE	Y N			
Distortion Pro. OAE	Y N			
Multi-Freq. Tymp	Y N			

4. In which of the following age groups have you fit hearing aids to in the last two years:

Age Group	Hearing Aids Fit (Yes/No)	Total Number
0-12 months	_____	_____
13-24 months	_____	_____
25-36 months	_____	_____

5. For professional services and/or for hearing aids, do you accept:

	For Services:		**For Hearing Aids:**	
	YES	NO	YES	NO
Blue Cross/Blue Shield	__	__	__	__
Medicaid	__	__	__	__
Indian Health Services	__	__	__	__
Other_____	__	__	__	__

6. To help the Consortium develop a list of audiologists in Idaho, please indicate your name, address, e-mail address, phone and fax number below. This information will not be made public unless you want to be placed on the list for parents. Your e-mail address and fax number will not be included on that referral list..

Name: _____

Address: _____

_____

E-mail address: _____

Phone Number: _____

Fax Number: _____

7. WOULD YOU LIKE TO BE PLACED ON A LIST TO BE GIVEN TO PARENTS? YES NO
IF YES, PLEASE COMPLETE THE FOLLOWING:

REFERRAL ADDRESS AND PHONE NUMBER (Please list your main referral address and at what specific hospitals, if any, you conduct services):

ADDRESS: _____
Street City State Zip

PHONE NUMBER: _____

ADDRESS: _____
Street City State Zip

PHONE NUMBER: _____

ADDRESS: _____
Street City State Zip

PHONE NUMBER: _____

Hospitals where you conduct services _____

_____ _____

Thank you for your help. Please return questionnaire in the postage-paid envelope provided or fax it to the Council at (208) 334-0828. If you have questions, you may call the Council at (208) 334-0879 or toll free at (800) 433-1323.