ND Early Hearing Detection & Intervention

Audiology Reporting Form

fax completed form to 701-858.3483

Patient Information

Child's name (Last, First, MI): ____

Date of birth: __________________ **Gender:** ☐ male ☐ female **Place of Birth:** ☐ home ☐hospital (name)______________

Mother's Name: ______________________________ **Father's Name:** ______________________________

Address,City, State, Zipcode: ____ **Phone:** ________________

Primary Care Physician: ____

OUTPATIENT SCREENING RESULT

Date of Screen:__________________________________ **Device Type:** ______________________________________

Name & Agency of Screener: ____

Technology used:	Left Ear Results:	Right Ear Results:
☐ DPOAE ☐ TOAE ☐ AABR	☐ Pass ☐ Refer ☐ Not Screened (list reason) __________________________	☐ Pass ☐ Refer ☐ Not Screened (list reason) __________________________

AUDIOLOGICAL ASSESSMENT SESSION RESULTS

Date of Assessment:_____________________________ **Screened/Tested by:**______________________________

Testing methods used: (mark all appropriate)

☐ ABR	☐ OAE	☐ DPOAE ☐ TOAE	☐ Behavioral	☐ BOA ☐ VRA ☐ CPA
☐ AABR	☐ Tymp	☐ 226 Hz ☐ 1000 Hz		

LEFT Ear:	RIGHT Ear:
Type of Hearing Loss ☐ Normal ☐ Mixed ☐ Auditory Neuropathy ☐ Sensorineural ☐ Conductive (transient) ☐ Not Yet Determined ☐ Conductive (permanent)	**Type of Hearing Loss** ☐ Normal ☐ Mixed ☐ Auditory Neuropathy ☐ Sensorineural ☐ Conductive (transient) ☐ Not Yet Determined ☐ Conductive (permanent)
Degree of Hearing Loss: ☐ Mild ☐ Profound ☐ Moderate ☐ Unknown Severity ☐ Severe	**Degree of Hearing Loss:** ☐ Mild ☐ Profound ☐ Moderate ☐ Unknown Severity ☐ Severe
Amplification: **Type:** ☐ air conduction ☐ bone conduction ☐ cochlear implant **Style:** ☐ BTE ☐ ITE/Canal	**Amplification:** **Type:** ☐ air conduction ☐ bone conduction ☐ cochlear implant **Style:** ☐ BTE ☐ ITE/Canal

Next Appointment(s) & Provider:____

Recommendations/Notes: