**Hearing Screening Referral**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear parent/guardian:

The hearing screening recently performed at school indicates that your child is in need of further evaluation. This does not mean that your child has a hearing loss, but it does mean that they should be evaluated by an audiologist or a medical profession. We urge you to give this your immediate attention.

Please make an appointment with your child’s primary care provider or audiologist as soon as possible. It is important to know the outcome of the professional examination, so please return this for to the school nurse with the results of the exam. If you have any questions, please contact the school health office.

Sincerely,

School Nurse

Screening Results: All students are tested at 25 dB (Pass/Fail)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hz | 500 (optional) | 1000 | 2000 | 4000 | Notes |
| Right |  |  |  |  |  |
| Left |  |  |  |  |  |

Dear medical professional:

Please complete the appropriate portion of the form and return to the patient so it may be brought back to the school nurse.

I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 Name Date

|  |  |
| --- | --- |
| **MEDICAL**   * Normal hearing * Medically treatable * Not medically treatable * Outer ear: * Middle ear: * Inner ear: * Refer to audiology * Further comments: | **AUDIOLOGICAL**   * Normal hearing * Conductive hearing loss * Mixed hearing loss * Sensorineural hearing loss * Refer to physician * Amplification evaluation * Further comments: |

Comments or follow up required for school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_