Office of the School Nurse

HEARING SCREENING REFERRAL

Date: ____________________

To: Parents of ________________________________

School health officials have checked your child's hearing. The findings indicate:
_____ your child should be scheduled for a complete examination by your primary health care provider.
_____ your child should be scheduled for an audiology exam.

1. Return the form completed by the physician/audiologist to the school nurse after your child has been evaluated.
2. If you have any questions concerning the screening results or any problem getting an appointment, please contact "*insert name and school number*".

School Audiogram Results (*Record db that each Hz was heard)*

RIGHT		**LEFT**	
500@	2000@	500@	2000@
1000@	4000@	1000A	4000@

History: OTM____ Fluid____ E.T.Dysf.____ Tubes____ Not Known ____
Tympanomatry: Type A______ Type B ______ Type C ______ Not Done ____
OAE: Pass _______ Fail _______ Not Done _______
Visual Inspection: Canal ____ T.M. ____

Comments:____

INFORMATION TO SCHOOL NURSE

1. Assessment: ____
2. Plan: ____
3. Recommendations: ____
4. Follow up scheduled/due on: ____
5. Needs repeat Audiogram _____ or Tympanogram _____ on ___________________

____
Physician's signature Date

1)Original to physician 2) Copy returned to school nurse 3) Copy for student file