New Jersey Department of Health
Child Health Services

HEARING SCREENING REPORT

Name of Child: _____ Date of Birth: _____

Primary Language
(if other than English, please specify): _____ Sex: ☐ Male ☐ Female

Name of Primary Care Provider: _____

Name of Screener: _____ ☐ RN ☐ APN ☐ Other _____

Telephone Number: _____ **Screening Date:** _____

***Screening equipment**:*

☐ *Audiometer:* _____ *(Mfgr./Model)* ☐ *Tympanometer:* _____ *(Mfgr./Model)* ☐ *OAE*: _____ *(Mfgr./Model)*

CASE HISTORY *(Check appropriate answers)*:

☐ Pass ☐ Refer (*if any boxes are checked "yes" in this section)*

	No	Yes	Right	Left	Unable to Assess
☐ Does child have or think he/she has a hearing loss? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child think he/she hears better in one ear? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Has child ever had a sudden or rapid progression of hearing loss? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child have ringing or noises in his/her ear(s)? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child use hearing aid(s)? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child use classroom amplification?	☐	☐			☐
☐ Has child had recent drainage from his/her ear(s)? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child have pain or discomfort in his/her ear(s)? If yes, which ear(s)?	☐	☐	☐	☐	☐
☐ Does child consider dizziness to be a problem for him/her?	☐	☐			☐

VISUAL/OTOSCOPIC INSPECTION OF EARS:

Overall Findings: ☐ Pass ☐ Refer (*if either ear is affected)*

Right Ear		Left Ear
☐	Refer for cerumen management	☐
☐	Refer for medical evaluation	☐
☐	Cannot Screen *	☐
☐	Did Not Screen *	☐

* Indicate why screening was not performed and/or any other comments below.

Comments: _____

_____

PURE TONE SCREENING:

Overall Findings: ☐ Pass ☐ Refer *(if "NR" is noted at any pitch for either ear)*

Screen at 20dBHL R = Response Present NR = No Response CNS = Cannot Screen DNS = Did Not Screen

	1000 Hz				2000 Hz				4000 Hz			
Right Ear	☐R	☐NR	☐CNS*	☐DNS*	☐R	☐NR	☐CNS*	☐DNS*	☐R	☐NR	☐CNS*	☐DNS*
Left Ear	☐R	☐NR	☐CNS*	☐DNS*	☐R	☐NR	☐CNS*	☐DNS*	☐R	☐NR	☐CNS*	☐DNS*

* Indicate why screening was not performed and/or any other comments below.

Comments: _____

_____

Child Health Services
HEARING SCREENING REPORT, Continued

Name of Child: Date of Birth:

TYMPANOMETRY SCREENING (WHEN APPLICABLE):

Overall Findings: ☐ Pass ☐ Refer *(if abnormal tympanometry screening is noted for either ear)*

☐ Tympanometry screening is not part of the screening protocol at this facility

Right Ear		Left Ear
☐	Pass	☐
☐	Refer	☐
☐	Cannot Screen *	☐
☐	Did Not Screen *	☐

* Indicate why screening was not performed and/or any other comments below.

Comments: _____

_____

OTOACOUSTIC EMISSION SCREENING (WHEN APPLICABLE):

Overall Findings: ☐ Pass ☐ Refer *(if either ear is affected)*

☐ Otoacoustic emission screening is not part of the screening protocol at this facility

Right Ear		Left Ear
☐	Pass	☐
☐	Refer	☐
☐	Cannot Screen *	☐
☐	Did Not Screen *	☐

* Indicate why screening was not performed and/or any other comments below.

Comments: _____

_____

REFERRAL RECOMMENDATIONS/COMMENTS:

Referred for:

☐ Rescreening: _____ Weeks _____ Months Date (if known): _____

☐ "Preliminary Pass" Recall (within 2 months of original screening date):

_____ Weeks _____ Months Date (if known): _____

☐ Audiologic Evaluation

☐ Medical Evaluation

☐ Other

Comments: _____

_____

Authorization is hereby given to the Consultant Agency/Provider to release their findings and recommendations to the Referring Agency.

	Name (Print)	Signature	Date
Parent or Guardian:			
Witness:			
Health Care Provider:			

TO BE COMPLETED BY CONSULTANT AGENCY/PROVIDER

Findings and Recommendations:

_____

_____

_____

	Name (Print)	Signature	Date
Health Care Provider:			