OAE Hearing Screening Form

Network _____ **Child's Name**_____

Child Information

Child's ID # _____ **Date of Birth:** (____/____/____)

☐ **Male** ☐ **Female**

Indicate whether Initial Screen, Periodic Rescreen, or Follow-up Rescreen, and provide corresponding information:

☐ **Initial Screen** – Screened for hearing loss at birth? ☐ Unknown ☐ Not screened ☐ Passed ☐ Referred

☐ **Follow-up Rescreen** – Performed after referral for Medical or Audiological Follow-up

☐ **Periodic Rescreen** – ☐ Annual ☐ Semi-annual ☐ Other _____

Hearing Screening Data

Screener:

Name _____

Title _____

Location:

☐ Home ☐ Daycare setting

☐ Center ☐ Other _____

☐ Part C Program

Child's LEFT Ear

❶ **Visual Inspection**

☐ *Refer* — **Date** (___/___/___) → **Follow-up**

☐ *Pass*

❷ **1st OAE** **2nd OAE**

Date (___/___/___) (___/___/___)

☐ *Can't test* ☐ *Can't test*

☐ *Refer* ☐ *Refer*

☐ *Pass* ☐ *Pass*

Follow-up

☐ **Medical** → *Rescreen after medical treatment & record results on additional Screening Form.*

(___/___/___)

Target date

If OAE Rescreen following medical treatment does not result in a Pass

☐ **Audiological** → *If child has a permanent hearing loss, refer to Early Intervention.*

(___/___/___)

Target date

Notes:

_____

_____

Child's RIGHT Ear

❶ **Visual Inspection**

☐ *Refer* — **Date** (___/___/___) → **Follow-up**

☐ *Pass*

❷ **1st OAE** **2nd OAE**

Date (___/___/___) (___/___/___)

☐ *Can't test* ☐ *Can't test*

☐ *Refer* ☐ *Refer*

☐ *Pass* ☐ *Pass*

Follow-up

☐ **Medical** → *Rescreen after medical treatment & record results on additional Screening Form.*

(___/___/___)

Target date

If OAE Rescreen following medical treatment does not result in a Pass

☐ **Audiological** → *If child has a permanent hearing loss, refer to Early Intervention.*

(___/___/___)

Target date

Notes:

_____

_____

Time Data

Approximate total time with child required for screening (in minutes):

1st OAE _____ **2nd OAE** _____