Diagnostic Follow-up Form

CENTER ID ____________________ **CHILD'S ID #** ____________ **CHILD'S NAME** ______________________

FOR MEDICAL EXAM ONLY

Date: (___/___/___) ☐ MD Name of person performing service: ____________________________________

Medical service(s) performed: ____

☐ Otoscopy ☐ Pneumatic Otoscopy ☐ Tympanometry ☐ Other ____________________________

Diagnosis: ☐ Normal Exam ☐ Cerumen ☐ Middle ear disorder (describe): __________________________

☐ Other: ____

Follow-up Recommendation(s) and date by which recommendation should be completed: (check all that apply)

☐ None

☐ Repeat hearing screening (___/___/___) ☐ Audiological evaluation (___/___/___)

☐ Further medical evaluation (___/___/___) ☐ Referral to Early Intervention (___/___/___)

☐ Medical treatment (___/___/___) ☐ Other ________________________ (___/___/___)

(describe) ________________________ ____

FOR AUDIOLOGICAL EXAM ONLY

Date: ___________Name of person performing service: ____________________________________

Audiological services performed: ☐ ABR ☐ Behavioral ☐ Other ____________________________

Hearing Status: ☐ Not yet confirmed ☐ Normal hearing, no loss ☐ Hearing loss (circle type & degree below)

Type	Left ear:	fluctuating conductive / permanent conductive / sensorineural / mixed / normal
	Right ear:	fluctuating conductive / permanent conductive / sensorineural / mixed / normal
Degree	Left ear:	mild / moderate / severe / profound / normal
	Right ear:	mild / moderate / severe / profound / normal

Follow-up Recommendation(s) and date by which recommendation should be completed: (check all that apply)

☐ None ☐ Further audiological evaluation (___/___/___)

☐ Repeat hearing screening (___/___/___) ☐ ABR ☐ Behavioral

☐ Further medical evaluation (___/___/___) ☐ Referral to Early Intervention (___/___/___)

☐ Other ____________________ (___/___/___)

Additional Notes: ____

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To the Audiologist or Physician:

A. Please complete this form and return all copies to:

Name: ______________________________

Address: ______________________________

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B. Inform the Screening Coordinator of results:

Name: ______________________________

Phone: ______________________________

The completed form should be returned as soon as the initial evaluation is completed, but no later than 4 weeks from the date of referral.