Instructions: We want to know what you think about the Infant Hearing Screening and Assessment Program (IHSAP) that all Ohio hospitals are required to do. Please answer all the questions as best you can. There are no right or wrong answers. The best answer is one which tells how you honestly feel or what you think. Your answers will be confidential. Thank you for your help!

1. When your baby was born, did you know that all babies in Ohio are required to be checked to find out if they have a risk indicator for hearing loss? (A risk indicator is a reason to check a baby for possible hearing loss.)
   _____ Yes  _____ No

2. There are about a dozen risk indicators for which babies should be checked for hearing loss (such as being born very small, receiving certain medicine, or having relatives who were born with a hearing loss). Did someone check your baby for risk indicators like these before he or she left the hospital?
   _____ Yes  _____ No  _____ Don't Know
3. Did your baby have a risk indicator for hearing loss?

- Yes (answer 4-7)
- No
- Don't Know

(To #8 on page 3)

4. Who told you your baby had a risk indicator? (check all that apply)

- Doctor
- Nurse
- Other
- Audiologist
- Screening Aide

Specify

5. How was it explained that your baby had a risk indicator(s)?
(circle the number that best reflects your opinion)

a. Did you know what you were supposed to do next?

Very clear

1 2 3 4 5

Very confusing

b. Did you understand the answers to your questions?

Definitely

Yes

1 2 3 4 5

Definitely

No

c. Could this have been explained better? (use the back of the page if necessary)

6. How did you feel when you were told your baby had a risk indicator for hearing loss?
(circle the number that best reflects your feelings at the time)

a. not worried

1 2 3 4 5

very worried

b. supported

1 2 3 4 5

abandoned

c. calm

1 2 3 4 5

angry

7. In the weeks after your baby’s birth, did you feel afraid, worried, or angry because your baby had a hearing loss risk indicator?

Definitely

Yes

1 2 3 4 5

Definitely

No
After Your Baby Was Born

8. Not counting the risk indicators, has your baby ever had a hearing test?

   ____ Yes (go to #9-13)    ____ No (go to #14)    ____ Don’t Know

9. What were the results of the hearing test?
   ____ normal hearing (answer 10-13, then go to #23)
   ____ needed more tests before we would know (answer 10-13, then go to #14)
   ____ hearing loss (answer 10-13, then go to #14)

10. Who explained the results of the hearing test to you?
    ____ Doctor    ____ Nurse    ____ Other __________________________
    ____ Audiologist    ____ Screening Aide Who?

11. Please tell us about the hearing tests.
    a. Did you understand the results of the testing?    ____ Yes    ____ No
    b. How long did it take to get the hearing test? ______________________________
       Was this too long?    ____ Yes    ____ No
    c. Did you understand the answers to your questions?    ____ Yes    ____ No
    d. Did you understand what you were supposed to do next?    ____ Yes    ____ No

12. After the hearing tests were done, were you afraid, worried, or angry?

    Definitely
    Not  No  Maybe  Yes  Definitely
    1  2  3  4  5

   If yes, explain why you felt that way and how these negative effects could have been avoided.
   (use the back for more space if necessary)

13. Was it worth the time, cost, and worry to find out your child might have a hearing loss?

    Definitely
    Yes  Yes  Maybe  No  Definitely
    1  2  3  4  5
14. Does your child have a permanent hearing loss?

<p>| | | | | | | |</p>
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<tr>
<td></td>
<td>Yes (go to #15-19)</td>
<td>No</td>
<td>Don t Know</td>
<td>Don t Know</td>
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15. As best you can, describe your child s severity of hearing loss by putting an x on the line for each ear at the appropriate place.

| Left Ear | Normal | Mild | Moderate | Severe | Profound | Don t Know |
| Right Ear | Normal | Mild | Moderate | Severe | Profound | Don t Know |

16. When you first found out that your child had a hearing loss, how well did you understand how his or her hearing loss would affect . . .

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<tbody>
<tr>
<td>a. your child s medical needs?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Did not understand at all</td>
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<td>b. your family s finances?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Did not understand at all</td>
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<td>c. your child s success in school?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Did not understand at all</td>
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<td>d. your child s ability to make friends?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>Did not understand at all</td>
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17. Do you think your child s hearing loss was found

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<tr>
<td>too early</td>
<td>about right</td>
<td>too late</td>
<td></td>
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<td></td>
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<tr>
<td>1</td>
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18. How old was your child when you were told exactly what type of hearing loss he or she had? ________________

19. The tests to decide my child had a hearing loss took:

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<tr>
<td>about the right amount of time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>too long</td>
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</table>
20. Have you and/or your child received any special services to help with his or her hearing loss?

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21. Does your child wear a hearing aid?  ____ Yes  ____ No

22. We want to know more about the services your child has received (or is receiving) to help with his or her hearing loss (services could include speech therapy, visits to doctors, home visits, a special early intervention program, and others). In the space below, list up to 4 services your child receives that you think are most important and tell a little bit about them.

<table>
<thead>
<tr>
<th>Name of Agency Providing Service</th>
<th>Brief Description of Service</th>
<th>Age of Child When Service Began</th>
<th>Quality of Service</th>
</tr>
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<tbody>
<tr>
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<td></td>
<td>Excellent (1)</td>
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<td>1.</td>
<td></td>
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<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<td>1 2 3 4 5</td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.</td>
<td></td>
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<td>1 2 3 4 5</td>
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23. Have your child's eyes been tested?  ____ Yes  ____ No

24. Were you ever referred to the Bureau for Children with Medical Handicaps (BCMH)?  ____ Yes  ____ No

25. Were you referred to early intervention?  ____ Yes  ____ No

   If yes, who referred you?  _______________________________________

26. Does your child have an Individualized Family Services Plan (IFSP)?  ____ Yes  ____ No
About You and Your Child

27. a. When was your child born? ____________ / ____ / ______  
   Month            Day        Year

b. Are you the child’s __ Mother ____ Father ____ Foster Parent  
   ____ Grandparent ____ Other ____ Foster Parent  
   (Specify)

c. To what group does your child belong? (optional)  
   ____ Caucasian ____ Hispanic ____ Pacific Islander  
   ____ African American ____ Asian ____ Native American  
   ____ Other

d. What is your highest level of education?  
   ____ some high school ____ college degree  
   ____ high school graduate/GED ____ graduate degree  
   ____ some college or vocational school after high school

e. How many members live at home in your family? ____ children ____ adults

f. County where you live: ____________________

28. If we want to talk more about any of your answers, is it okay if we call you?  
   ____ Yes ____ No

Please give us your name, phone number, and best time to call:

   Name: __________________________________________
   Best phone number: ________________________________
   Best time to call: ________________________________

THANK YOU FOR YOUR HELP!! Please return the questionnaire in the postage-paid envelope to Utah State University and return the postage-paid postcard to your hospital so they won’t bother you with follow-up requests.