Utah Department of Health and the Newborn Hearing Screening Committee
AUDIOLOGIST QUESTIONNAIRE

1. Please check each of the following that are applicable for you.

___A. I currently provide diagnostic hearing evaluations for infants 0-6 months of age, including otoacoustic emissions (OAE) and auditory brainstem response (ABR) testing. I would like my name included on a referral list for parents whose infants need diagnostic hearing evaluations.

___B. I currently provide diagnostic hearing evaluations for infants 6-30 months of age, including OAE, ABR, and soundfield visual reinforcement audiometry. I would like my name included on a referral list for parents whose children need diagnostic hearing evaluations.

___C. I currently provide hearing aid evaluations and fittings for infants. I would like my name included on a referral list for parents whose children need hearing aids.

___D. I am interested in providing infant hearing diagnostic evaluations in the future, and would like information on how I can obtain the necessary skills and/or equipment.

___E. I am interested in providing hearing aids for infants in the future, and would like information on how I can obtain the necessary skills and/or equipment.

___F. I am not interested in providing infant hearing diagnostic evaluations or hearing aids at this time, and do ***not*** wish to be included on a parent referral list.

2. If you are interested in being included on a parent referral list, please check the following tests/services you provide for infants.

____ Click evoked ABR

____ Tone pip evoked ABR

____ Bone conduction ABR

____ Click evoked otoacoustic emissions

____ Facilities to sedate infants when necessary

____ Distortion product otoacoustic emissions

____ Visual reinforcement audiometry

____ Play audiometry

____ Real ear measurements

____ Tympanometry

3. Comments: _____

_____

_____

Signature _____ Date _____

Print Name _____ Agency _____

Business Address _____ Business Phone _____