# OAE Hearing Screening Form

**Program** _____ **Child's Name** _____

**Child Information**

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

☐ **Male** ☐ **Female**

Screened for hearing loss at birth? ☐ Unknown ☐ Not screened ☐ Passed ☐ Referred

**Hearing Screening Outcomes**

**Screener's Name:** _____

## Child's LEFT Ear

### Visual Inspection

☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance

☐ *Pass*

**1st OAE** (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

**2nd OAE** (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
**Middle Ear Consultation**
(by health care provider)

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed.

**Notes:**

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## Child's RIGHT Ear

### Visual Inspection

☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance

☐ *Pass*

**1st OAE** (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

**2nd OAE** (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
**Middle Ear Consultation**
(by health care provider)

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed.

**Notes:**

_____

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**Time Data**

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

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