

OAE Hearing Screening Form – 2 Step Protocol

Center ID _____

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

1 Visual Inspection

Refer — Date (___/___/___)

Pass

2 1st OAE

Date (___/___/___)

- Can't test
 Refer
 Pass

2nd OAE

(___/___/___)

- Can't test
 Refer
 Pass

Notes:

Follow-up

Medical —
(___/___/___)
Target date

Rescreen after medical treatment & record results on additional Screening Form.

Audiological —
(___/___/___)
Target date

If child has a permanent hearing loss, refer to Early Intervention.

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

Child's RIGHT Ear

1 Visual Inspection

Refer — Date (___/___/___)

Pass

2 1st OAE

Date (___/___/___)

- Can't test
 Refer
 Pass

2nd OAE

(___/___/___)

- Can't test
 Refer
 Pass

Notes:

Follow-up

Medical —
(___/___/___)
Target date

Rescreen after medical treatment & record results on additional Screening Form.

Audiological —
(___/___/___)
Target date

If child has a permanent hearing loss, refer to Early Intervention.

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

Time Data

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

1st OAE _____ 2nd OAE _____