Parent Questionnaire
about
Ohio Infant Hearing Screening and Assessment Program (IHSAP)

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!

When Your Baby Was Born

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 (go 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
____ Don t Know (go to #14)

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				Definitely Yes
No	Maybe	Yes		
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				Definitely No
Yes	Maybe	No		
1	2	3	4	5

If Your Child Has A Hearing Loss

14. Does your child have a permanent hearing loss?

____ Yes (go to #15-19)

____ No
____ Don t Know (go to #23)

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.

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

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 . . .

		Understood very well				Did not understand at all
a.	your child s medical needs?	1	2	3	4	5
b.	your family s finances?	1	2	3	4	5
c.	your child s success in school?	1	2	3	4	5
d.	your child s ability to make friends?	1	2	3	4	5

17. Do you think your child s hearing loss was found

too early		about right		too late
1	2	3	4	5

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:

about the right amount of time	1	2	3	4	5	too long

20. Have you and/or your child received any special services to help with his or her hearing loss?

____ Yes (go to #21-22) ____ No (go to #23)

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.

Name of Agency Providing Service	**Brief Description of Service**	**Age of Child When Service Began**	**Quality of Service** Excellent 1 2 3 4 5 Poor
1.			1 2 3 4 5
2.			1 2 3 4 5
3.			1 2 3 4 5
4.			1 2 3 4 5

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 _____
(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.