

LOGO / Clinic Header, etc.

Dear Parent/Guardian:

Your child has been referred for a hearing exam by his/her primary care provider or your state hearing detection program. The exam will be conducted at (location) _____ on (date, time) _____, _____ using the internet to connect our locations. This will allow you to remain closer to home and save the time and expense of travel. You will be able to see and hear me as I complete the exam and we can discuss any concerns you may have prior to the examination.

It is very important that we determine if your child has a hearing loss so that intervention can take place as soon as possible. Because of this, please make every attempt to attend this appointment or reschedule in a timely manner.

We will be completing an auditory brainstem response (ABR) assessment of hearing acuity. This is a non-invasive diagnostic procedure in which self adhesive surface electrodes are placed on various locations on the head/neck of your child. The only requirement is your child's passive cooperation. In other words, your child may sleep through the assessment procedure (which is preferable). In order to increase the likelihood of sleep, you are encouraged to do the following:

1. Keep your child up late the night before the assessment.
2. Get your child up early in the morning the day of the assessment.
3. Do not allow your child to sleep in the car on the way to the assessment.
4. Feed him/her immediately prior to the assessment.
5. Bring any blanket/pacifier, etc. that your child finds soothing.

A crying and active child cannot be accurately tested in a timely manner. Anything that you can do to assist your child to sleep would be helpful. Your cooperation will be greatly appreciated and will greatly reduce the time it takes to complete the exam.

Please find some materials included with this letter that may help to explain the early hearing detection and intervention process.

If you have questions please contact my office at _____.

Pediatric Audiologist