

THERAPY 2000 HEARING SCREENING FORM

PATIENT NAME: _____ GENDER: _____ DOB: _____
 DATE: _____ SCREENER: _____

I. OTOSCOPIC SCREENING

II. AUDIOMETRIC SCREENING

Pure Tone (@25dB), if fail, test at 40dB

	Otoscopy	500Hz	1000Hz	2000Hz	4000Hz
Right Ear					
Left Ear					

Other Observations: _____

Patient is unable to condition to the audiometric screening.

Comments: _____

- *Failure Criteria:* A. 2 or more frequencies NOT heard @ 25dB in the same ear -AND/OR-
- B. 1 or more frequencies NOT heard @ 40dB

III. CASE HISTORY SCREENING

- | | |
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| <ul style="list-style-type: none"> <input type="checkbox"/> Craniofacial anomalies <input type="checkbox"/> Birth weight less than 1500 grams (3.3 lbs) <input type="checkbox"/> Congenital infection known or suspected to be associated with sensorineural hearing loss (i.e. toxoplasmosis, syphilis, rubella, CMV, or herpes) <input type="checkbox"/> Mechanical ventilation (> 5 days) <input type="checkbox"/> Respiratory depression @ birth (Apgar scores: 0-4 at 1 minute, or 0-6 @ 5 minutes) <input type="checkbox"/> Hyperbilirubinemia @ a level exceeding indication for exchange transfusion <input type="checkbox"/> Bacterial meningitis <input type="checkbox"/> Hx. of recurrent ear infections (> 4x/yr.) or persistent ear infection (> 3 months) <input type="checkbox"/> Multiple exposures to loud noises: <ul style="list-style-type: none"> ___ > 2x exposures > 1min/time (intensity level equivalent to gun shots or the loud part of a rock concert) ___ Average use of personal music players at 80% of the max. volume for at least 1 hour/day for <input style="width: 40px;" type="text"/> years. | <ul style="list-style-type: none"> <input type="checkbox"/> Parent's use of drugs/alcohol before or during pregnancy <input type="checkbox"/> Family hx. of Ushers, Treacher-Collins, Goldenhar, or Waardenburg syndrome <input type="checkbox"/> Family hx of congenital or childhood sensorineural hearing loss <input type="checkbox"/> Speech/language development delay <input type="checkbox"/> Parent concern re: child's hearing <input type="checkbox"/> Neurodegenerative disorders <input type="checkbox"/> Head injury <input type="checkbox"/> Ototoxic medications used >5 days <ul style="list-style-type: none"> ___ Chemotherapy agents ___ Aminoglycoside antibiotics ___ Certain loop diuretics ___ Chronic use of high dose Aspirin <input type="checkbox"/> Discharged from Neonatal Intensive Care <input type="radio"/> Newborn Hearing Screening Result: refer <p style="text-align: right; margin-top: 20px;"><i>• Failure criteria: Three or more boxes are checked or the last radio button is checked.</i></p> |
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SCREENING SUMMARY

- PASS** Patient's hearing is within normal limits. A routine hearing screening will be completed annually.
- FURTHER SCREENING BY THERAPY 2000 IS NEEDED**
 - Tympanometry is recommended. (Failed audiometric screening OR SLP suspects an ear infection.)
 - OAE is needed. (Audiometric screening couldn't be done AND:
 - a. parents/therapist suspect a hearing loss with a pass Case History, OR
 - b. unavailable Case History)
- FAIL**
 - Audiometric screening fail:** refer the patient to an audiologist.
 - Case History screening fail:** refer the patient to an audiologist.
 - Otoscopy screening fail:** refer the patient to an ENT physician.

Parent declined a hearing screening at this time. Reason: _____
 Parent signature on file. Date: _____ HY[j]fI[&h`gf]: _____

IMPORTANT REMINDERS:

- *Complete a call log in the patient's chart that includes a screening summary
- *Submit protocol by the first Monday morning of the coming month.