

RESULTS OF DIAGNOSTIC AUDIOLOGICAL EVALUATION

Child's name: _____ Parent's Name: _____
Date of birth: _____ Social Security Number: _____
Birth Hospital/ Facility: _____ Address: _____ Zip: _____
Phone: _____
Date of evaluation: _____

Results:	Right	Left	Degree of Loss:	Right	Left
Normal Hearing	_____	_____	Normal	_____	_____
Conductive Loss	_____	_____	Mild	_____	_____
Sensorineural Loss	_____	_____	Moderate	_____	_____
Mixed Loss	_____	_____	Severe	_____	_____
Central Loss	_____	_____	Profound	_____	_____

Method of Evaluation:

____ Click ABR ____ TEOAE ____ Tympanometry ____ BOA
____ Tone Burst ABR ____ DPOAE ____ High-Frequency Tymp ____ VRA
____ Bone Conduction ABR other: _____ ____ CPA

Recommendations:

____ Medical Follow-up ____ ENT Consult/Clearance ____ Amplification
____ Genetic Counseling ____ Other: _____
____ Audiological Re-Evaluation and/or monitoring (if yes) When/How often? _____

Early Intervention office referred to : _____ **Date referred:** _____

Comments: _____

_____	_____
Audiologist (type or print)	Clinic Name
_____	_____
Address	Phone
_____	_____
City State Zip	

Return this completed form with your report to:

Newborn Hearing Screening Program Administrator, PA Department of Health, Division of Newborn Disease Prevention & Identification, 7th Floor East Wing, Harrisburg, PA 17120. FAX: (717) 705-9386.
email : nbhs@state.pa.us

Questions may be directed to the program administrator at (717) 783-8143 or through the above email address.