OAE Hearing Screening Form

Screener's Name: _____

Child Information

Child's Name _____ ☐ **Male** ☐ **Female** **Date of Birth:** ____/____/____

Screened for hearing loss at birth? ☐ Unknown ☐ Not screened ☐ Passed ☐ Referred

Child's LEFT Ear

Visual Inspection ☐ *Pass* ☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance.

1st OAE (___/___/___) **2nd OAE** (___/___/___)

☐ *Can't test* → ☐ *Can't test**

☐ *Rescreen* → ☐ *Refer*

☐ *Pass* ☐ *Pass*

Schedule follow-up (___/___/___)

Middle Ear Consultation

(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)

After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed.

Notes:

_____

_____

Child's RIGHT Ear

Visual Inspection ☐ *Pass* ☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance.

1st OAE (___/___/___) **2nd OAE** (___/___/___)

☐ *Can't test* → ☐ *Can't test**

☐ *Rescreen* → ☐ *Refer*

☐ *Pass* ☐ *Pass*

Schedule follow-up (___/___/___)

Middle Ear Consultation

(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)

After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed

Notes:

_____

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This form is adapted from the ECHO Initiative OAE Hearing Screening Form.