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* — fill out referral form → Consult health care provider; conduct OAE screening after medical clearance.

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

☐ *Can't test* → ☐ *Can't test*
☐ *Rescreen* → ☐ *Refer**
☐ *Pass* ☐ *Pass*

***Refer-complete Referral Form for**
Middle Ear Consultation
to primary physician/health care provider.
After medical clearance, conduct an OAE rescreen, referring for audiological evaluation by a pediatric Audiologist for unsuccessful screenings.

Notes:

_____

_____

Child's RIGHT Ear

Visual Inspection ☐ *Pass* ☐ *Refer* — fill out referral form → Consult health care provider; conduct OAE screening after medical clearance.

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

☐ *Can't test* → ☐ *Can't test**
☐ *Rescreen* → ☐ *Refer*
☐ *Pass* ☐ *Pass*

***Refer-complete Referral Form for**
Middle Ear Consultation
to primary physician/health care provider.
After medical clearance, conduct an OAE rescreen, referring for audiological evaluation by a pediatric Audiologist for unsuccessful screenings.

Notes:

_____

_____

Addtional Hearing/SPOT Vision Screener Notes:_____

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