# Hearing Screening Referral Report

Date: _____

To the Parents of _____ D.O.B _____

School _____ Grade _____

Hearing screening was recently conducted at your child's school. The results of the hearing screening indicate that your child may have a hearing problem. Hearing problems can place your child at risk for learning difficulties. It is recommended that you take your child to his/her primary health care provider for further evaluation. If you have any questions concerning the screening results, please contact the school nurse. Please let the school nurse know if your child is already under a doctor's care for hearing problems or if you need assistance in finding a medical provider. **Please return the completed form to the school.**

**Pure Tone Hearing Screening Results:**

| | 1000 | 2000 | 4000 | Observation/comments |
|---|---|---|---|---|
| R | Pass___(20dB)<br>Not Pass____ | Pass___(20dB)<br>Not Pass ____ | Pass___(20dB)<br>Not Pass ____ | |
| L | Pass___(20dB)<br>Not Pass ____ | Pass___(20dB)<br>Not Pass ____ | Pass___(20dB)<br>Not Pass ____ | |

**EVALUATION RESULTS (to be completed by the healthcare provider):**

Diagnosis: _____

Treatment Plan: _____

Comments: _____

Signature: _____ Date:_____

**Content and Release of Information**

I, _____ *(parent/guardian)* of the above named child, hereby authorize the provider completing this report to return this completed form to:

_____

_____

for the specific purpose of notifying the school of any specific hearing problems, recommendations and instructions for teachers related to the child's hearing problems. This authorization expires upon submission of the completed form to the above named school.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment for services or eligibility for benefits for my child; however, if this form is not submitted to the school, I understand that the school may not have sufficient information to address special hearing needs for my child.

_____ _____

*(Signature of parent/guardian)* *(Date)*

**Please return form to** **From**

| | | | |
|---|---|---|---|
| Suzanne Blank, RN,BSN School Nurse | Specialist | | |
| Wynford Elementary School<br>3300 Holmes Center Rd.<br>Bucyrus, Ohio 44820 | Address | | |
| | City | State | ZIP |
| 419-562-4619<br>Fax: 419-563-2905 | Date | | |