

Early Hearing Detection and Intervention Diagnostic Reporting

Site:	Assessment Date:																						
Patient Name (Last, First, MI):	Medical Record Number:																						
Child Demographics:	Risk Factors																						
Date of Birth:	<input type="checkbox"/> None <input type="checkbox"/> NICU > 48 hours																						
Place of Birth:	<input type="checkbox"/> Congenital infections <input type="checkbox"/> Craniofacial anomalies																						
	<input type="checkbox"/> Family history of hearing loss <input type="checkbox"/> Other:																						
Mother/Guardian Information:																							
Name (Last, First, MI): _____																							
Address: _____																							
Phone: _____																							
Test Results:																							
Behavioral Method: VRA CPA Conventional Type of Loss: (normal, conductive, sensorineural, mixed)																							
(circle one) Right _____ Left _____																							
Frequency	250 500 750 1000 1500 2000 3000 4000 6000 8000																						
Right																							
Left																							
Sound Field																							
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Intervention Dates: Hearing loss confirmation _____ Decision to aid _____ Last Assessment _____ Fitting _____ Device Data: _____																							
Comments/Recommendations: _____																							
Assessment Performed By:																							
Child's Primary Care Provider:																							