

**GREAT NECK PUBLIC SCHOOLS**

**Health Services**

***Hearing Referral***

Date \_\_\_\_\_

Name \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Dear Parent:

The results of the school hearing screening showed that your child had some signs of hearing difficulty. A follow up by your physician is indicated. The results of this examination will assist school personnel in making all necessary modifications to your child's educational program.

**The form on the back should be completed by the examining physician and/or audiologist and returned to the school nurse.**

TO PHYSICIAN:

Report of school's threshold acuity test:

**Right Ear**

500 \_\_\_\_\_ dB

1000 \_\_\_\_\_ dB

2000 \_\_\_\_\_ dB

4000 \_\_\_\_\_ dB

6000 \_\_\_\_\_ dB

**Left Ear**

500 \_\_\_\_\_ dB

1000 \_\_\_\_\_ dB

2000 \_\_\_\_\_ dB

4000 \_\_\_\_\_ dB

6000 \_\_\_\_\_ dB

The following signs of hearing difficulty have been observed by school personnel:

Other special instructional services:

\_\_\_\_\_  
School Nurse

**AUDIOLOGIST'S REPORT AND MEDICAL FINDINGS**

**Threshold Screening**

O = Right Ear

X = Left Ear

**Frequency in Hertz**

	250	500	1000	2000	4000	6000	8000
0 dB							
10 dB							
20 dB							
30 dB							
40 dB							
50 dB							
60 dB							
70 dB							
80 dB							
90 dB							
100 dB							
110 dB							

Diagnosis: \_\_\_\_\_

Further medical procedures recommended:  
\_\_\_\_\_  
\_\_\_\_\_

Is hearing aid indicated?    Yes \_\_\_\_\_    No \_\_\_\_\_

Recommendations and remarks: \_\_\_\_\_

Please indicate where applicable:

- \_\_\_\_\_ Preferential classroom seating
- \_\_\_\_\_ Auditory training
- \_\_\_\_\_ Speech reading
- \_\_\_\_\_ Speech correction
- \_\_\_\_\_ Special education programs

Re-evaluation of this patient has been recommended in: \_\_\_\_\_ Months \_\_\_\_\_ Year

**Date of Exam** \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature & Stamp  
Address & Phone Number