Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

Diagnostic Follow-Up Form (referral from hearing screening)

Child's Name _____ **Date of Birth** _____

Middle Ear consultation (typically conducted by a health care provider)

Date: (____ / ____ / ____) ☐ MD Name of person performing service: _____

Medical service(s) performed:

☐ Otoscopy ☐ Pneumatic Otoscopy ☐ Tympanometry ☐ Other _____

Diagnosis & Treatment:

Ear: L / R

☐ / ☐ Normal (no condition or disorder detected)
☐ / ☐ Cerumen removal (wax)
☐ / ☐ PE tube blockage cleared
☐ / ☐ Middle ear disorder (describe):

_____
_____

☐ / ☐ Other: _____
_____

Follow-up recommendation(s) and date by which recommendation should be completed:
(check all that apply)

☐ None
☐ Repeat hearing screening (____/____/____)
☐ Audiological evaluation (____/____/____)
☐ Further medical evaluation (____/____/____)
☐ Referral to Early Intervention (____/____/____)
☐ Medical treatment (____/____/____)
☐Other _____ (____/____/____)

When medical clearance is given (outer and middle ear are clear)

Inner Ear Outcome **Audiological Evaluation (by pediatric audiologist)**

Date: (____/____/____) Name of person performing service: _____

Audiological Services performed: ☐ ABR ☐ Behavioral ☐ Other _____

Hearing Status: (check one box under Type and Degree for each ear)

Ear L / R Type of Loss

☐ / ☐ **Permanent loss (sensorineural, conductive, mixed)**
☐ / ☐ **Temporary loss (fluctuating conductive)**
☐ / ☐ **Normal - no loss**

Ear L / R Degree of Loss

☐ / ☐ **Mild**
☐ / ☐ **Moderate**
☐ / ☐ **Severe**
☐ / ☐ **Profound**
☐ / ☐ **Normal - no loss**

Follow-up recommendation(s) and date by which recommendation should be completed: (check all that apply)

☐ **None**
☐ **Repeat hearing screening (____/____/____)**
☐ **Further medical evaluation (____/____/____)**
☐ **ABR** ☐ **Behavioral**
☐ **Referral to Early Intervention (____/____/____)**
☐ **Other _____ (____/____/____)**

Health Care Provider Signature: _____ **Title:**_____ **Date:** _____

Please fax to (209) 238-4217 Attention: _____ ***Title:*** _____

Distribution: White - Parent Yellow - Health File

Mandatory
New 1/17
CF/H-7e