SURREY PLACE

2 Surrey Place,
Toronto ON M5S 2C2
416-925-5141
416-925-3402
infanthearing@surreyplace.ca

AUDIOLOGY COCHLEAR IMPLANT EVALUATION SUMMARY

Child's Name: Last First	Primary Contact (Parent/Legal Guardian) CAS ☐ Last First
DOB (y/m/d): GA(wks)	Residential Address No Change ☐
Gender M ☐ F ☐	Street Address _____ _____
Service Language English ☐ French ☐ Other:_____	City Postal Code _____ Previous address if moved:_____
Language Interpreter needed: _____	Home Phone / Other Phone
Has sibling identified with PHL? Yes ☐ No ☐ Unknown ☐	Primary Care Physician (if known): No Change ☐

COCHLEAR IMPLANT EVALUATION DETAILS

Cochlear Implant	Switch-on Date
Right Ear	☐ Date(y/m/d):
Left Ear	☐ Date(y/m/d):
CONSENT HAS BEEN OBTAINED TO SHARE INFORMATION WITH IHP FOR FOLLOW UP: Yes ☐ No ☐	

Comments:

Testing Audiologist (Print):_____ Signature:_____
(Last name, First name)

Future Audiology Assessment Date (y/m/d):_____ Date Of Test (y/m/d):_____

Personal information contained on this form is collected under the authority of The Health Protection and Promotion Act, R.S.O. 1990, c. H. 5 and is used by the Infant Hearing Program for follow-up and support services. Questions about this form should be directed to: Manager, Early Years (IHP) at infanthearing@surreyplace.ca.

HIGH RISK SURVEILLANCE SUMMARY

New to IHP ☐

Child's Name: Last First	Primary Contact (Parent/Legal Guardian) CAS ☐ Last First
DOB (y/m/d): GA(wks)	Residential Address No Change ☐
Gender M ☐ F ☐	Street Address _____ _____
Service Language English ☐ French ☐ Other:_____	City Postal Code _____ Previous address if moved:_____
Language Interpreter needed: _____	Home Phone / Other Phone
Has sibling identified with PHL? Yes ☐ No ☐ Unknown ☐	Email Address / Consent for email communication ☐
Consent to share information with IHP for follow-up Yes ☐ No ☐	Primary Care Physician (if known): No Change ☐

AUDIOLOGY SURVEILLANCE OUTCOME			NEXT STEP (CHOOSE ONE)	
Risk Factor:			Additional Audiology Surveillance	☐ ABR ☐ VRA ☐ PLAY
Protocol: ☐ Standard ☐ Intensive	Method: ☐ ABR ☐ VRA ☐ PLAY		Move to Audiology Assessment	☐
	Left Ear	Right Ear	Move to: ☐ 18 mo Surv Questionnaire ☐ 30 mo Surv Questionnaire	Due: _____/_____ yyyy mm
Pass	☐	☐	Discharge from Infant Hearing	☐ No additional Surveillance required
Refer	☐	☐		☐ Not at risk (details in Notes)
No Result/CNC	☐	☐		☐ No contact letter sent
Communication Checklist	☐ Passed ☐ Referred to PSL ☐ Did not compete			_____/_____/_____ yyyy mm dd
NOTES:				
Audiologist:_____ Last Name, First Name			Location	
Date: _____/_____/_____ yyyy mm dd			Future Appt Date (or recommended year and month: _____/_____/_____ yyyy mm dd	

AUDIOLOGY ASSESSMENT / HEARING AID EVALUATION OR RECHECK

New to IHP ☐

Child's Name: Last First		Primary Contact (Parent/Legal Guardian) CAS ☐ Last First	
DOB (y/m/d): GA(wks)		Residential Address No Change ☐	
Gender M ☐ F ☐	Risk Factor: ☐Yes ☐ No	Street Address _____ _____	
Service Language English ☐ French ☐ Other:_____		City Postal Code _____ Previous address if moved:_____	
Language Interpreter needed: _____		Home Phone	Other Phone
Has sibling identified with PHL? Yes ☐ No ☐ Unknown ☐		Email Address	Consent for email communication ☐
Consent to share information with IHP for follow-up	Yes ☐ No ☐	Primary Care Physician (if known): No Change ☐	
Comorbidities:		Complex Factors:	
☐ Autism ☐ Syndrome ☐ Other (specify):	☐ Cerebral Palsy ☐ Impaired Vision	☐ Delayed Fitting ☐ Middle Ear Disfunction ☐ Unreliable Respondent	☐ Inconsistent Hearing Aid Use ☐ Late Identification ☐ Other (specify):

ASSESSMENT RESULTS: ☐ ABR (dBeHL) ☐ VRA (dBHL) ☐ Play (dBHL) ☐ Conventional (dBHL)

Left Ear		Freq (kHz)	Right Ear	
Air	Bone		Air	Bone
		0.5		
		1.0		
		2.0		
		4.0		

HEARING LOSS TYPE			
☐		Sensorineural	☐
☐		Conductive	☐
☐		Mixed	☐
☐		Unknown	☐
☐		None	☐

HL	PHL	HRG LOSS	HL	PHL
☐	☐	Yes	☐	☐
☐	☐	No	☐	☐
☐	☐	CNC	☐	☐

AUDITORY NEUROPATHY SPECTRUM DISORDER

☐	Definite
☐	Suspected
☐	Not Suspected

LITTLEARS AUDITORY QUESTIONNAIRE

☐ Electronically ☐ Independently in office ☐ Interview - 1° caregiver ☐ Interview-family/friend	☐ Interview – interpreter ☐ Mail ☐ Telephone ☐ Other:
Tool #:	Score:

Left Hearing Aid		Right Hearing Aid	
☐ New Prescription ☐ Recheck ☐N/A		☐ New Prescription ☐ Recheck ☐N/A	
Hearing Aid Model: ☐ No Change		Hearing Aid Model: ☐ No Change	
☐AC ☐BC ☐CROS	☐Own ☐ Loaner	☐AC ☐BC ☐CROS	☐Own ☐ Loaner
RECD ☐Measured ☐Predicted ☐Used other ear values ☐Used previously measured values		RECD ☐Measured ☐Predicted ☐Used other ear values ☐Used previously measured values	
MPO Measured: ☐ Yes ☐ No		MPO Measured: ☐ Yes ☐ No	
SII: Soft (55dB): Avg (65 dB):		SII: Soft (55dB): Avg (65 dB):	

LEFT EAR FM	NON SPECIFIC FM	RIGHT EAR FM
☐New Rec ☐In Use ☐N/A	☐New Rec ☐In Use ☐N/A	☐New Rec ☐In Use ☐N/A
For: ☐ Home ☐ School ☐ Personal FM + HA ☐ Ear Level FM only	For: ☐ Home ☐ School ☐ Soundfield ☐ Portable Speaker	For: ☐ Home ☐ School ☐ Personal FM + HA ☐ Ear Level FM only

NEXT STEPS: (TICK ALL THAT APPLY)	
Move to Surveillance: ☐ VRA/PLAY ☐Questionnaire	/ / YY MM DD
Medical referral to physician	/ / YY MM DD
Medical referral to ENT requested	/ / YY MM DD
Referral to IHP Social Worker in local region	☐ Yes ☐ No ☐ Done
Referral for Communication Development Services:	☐ ASI ☐ ASL ☐ SLI
Communication Development Plan Completed	☐ Yes ☐ In Progress ☐ No
Recommendation for Assistive Technology	☐ HA ☐ CI ☐ FM ☐ Done
Referral for consult for sedated ABR	☐
Transfer To:	☐
Discharge from Audiology	☐

NOTES:

Audiologist: _____ Location:_____

Date of Test: Future Appt:

YY MM DD YY MM DD

OUT OF REGION AUTHORIZATION

NOTES:

☐ Declined
☐ Approved
☐ Expires

YY MM DD