SURREY PLACE

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Audiology Assessment / Hearing Aid Evaluation or Recheck

New to IHP ☐

Child's Name (Last, First)	Primary Contact - Parent/Legal Guardian- (Last, First) CAS ☐
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: ☐ Autism ☐ Cerebral Palsy ☐ Syndrome ☐ Impaired Vision ☐ Other (specify):	Complex Factors: ☐ Delayed Fitting ☐ Inconsistent Hearing Aid Use ☐ Middle Ear Disfunction ☐ Late Identification ☐ Unreliable Respondent ☐ Other (specify):

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

Left Ear Air	Left Ear Bone	Freq (kHz)	Right Ear Air	Right Ear 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	☐ Interview – interpreter
☐ Independently in office	☐ Mail
☐ Interview - 1° caregiver	☐ Telephone
☐ Interview-family/friend	☐ 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: YY MM DD Future Appt: YY MM DD

OUT OF REGION AUTHORIZATION

NOTES:

☐ Declined
☐ Approved
☐ Expires YY MM DD