

# Otoacoustic Emission (OAE) Hearing Screening Referral Report

Date: \_\_\_\_\_

To the Parent/Caregiver of \_\_\_\_\_ D.O.B \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Your child is being referred for further evaluation because he/she failed our hearing screening procedure in our school. We are using a hearing screening called "Otoacoustic Emissions (OAE)." This is an objective test that records a physiological response from the inner ear. Hearing problems can place your child at risk for learning difficulties. It is recommended that you take your child to his/her primary care provider or audiologist for further evaluation. If you have any questions concerning the screening results, please contact the school nurse. Please let the school nurse know if your child is already under a doctor's care for hearing problems or if you need assistance in finding a medical provider. Please return the completed form to the school.

## Otoacoustic Emission (OAE) Testing Results

Otoacoustic Emissions (OAE)	Pass	Refer	Comments
Right Ear			
Left Ear			

"Pass" OAE means that the child has normal outer hair cell function; however, it does not rule out a mild hearing loss. OAEs do not assess hearing acuity. A child's peripheral hearing system has to be normal or within a normal range to pass this hearing procedure. A child with a mild hearing loss up to 30-35dB can pass this screening.

"Refer" OAE can mean that the 1) the child has a potential hearing loss or, 2) the child may have middle ear problems that affects the ability to record a response from the inner ear.

## EVALUATION RESULTS (to be completed by the healthcare provider):

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

Treatment Plan: \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Please return form to: \_\_\_\_\_

## CONSENT AND RELEASE OF INFORMATION

I, \_\_\_\_\_ (parent/caregiver) of the above named child, hereby authorize the provider completing this report to return this completed form to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

for the specific purpose of notifying the school of any specific hearing problems, recommendations and instructions for teachers related to the child's hearing problems. This authorization expires upon submission of the completed form to the above named school.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment for services or eligibility for benefits for my child; however, if this form is not submitted to the school, I understand that the school may not have sufficient information to address special hearing needs for my child.

\_\_\_\_\_  
(Signature of parent/caregiver)

\_\_\_\_\_  
(Date)