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 <u>returned to the school nurse</u>.

<u>TO PHYSICIAN:</u>

Report of school's threshold acuity test:

Right Ear	**Left Ear**
500_____dB	500_____dB
1000_____dB	1000_____dB
2000_____dB	2000_____dB
4000_____dB	4000_____dB
6000_____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