Referral for Diagnostic Audiological Evaluation

Baby's Name: _____ Date of Birth: _____

Hospital: _____ Medical ID #: _____

Parent or Guardian Contact Information:

Name: _____

Address: _____

_____

Phone : _____

Baby's Primary Care Physician:

Name: _____

Address: _____

_____

Phone: _____

Audiologist to whom the family was referred:

Name: _____

Address: _____

_____

_____
Date of Referral

Phone: _____

Hearing Screening Results Attached ☐ Yes ☐ No

I hereby give my permission to staff at the above-named hospital to release medical information necessary to complete an audiological evaluation for my child to the above-named audiologist. I also give permission for the audiologist to share information about the results of the audiological evaluation with the staff at the baby's birth hospital and the Utah Department of Health. The information will be used to ensure that appropriate and timely medical, educational, and audiological services are made available to my child. I understand that this information will not be shared with unauthorized people.

_____
Signature of Parent Date

☐ I have received information on early intervention services in Utah.

To the Audiologist: Please complete the reverse side of this form and return it to:

Utah Department of Health
Hearing, Speech & Vision Services
Box 144620
Salt Lake City, UT 84114-4620

Phone: (801) 584-8215

The completed form should be returned as soon as the initial evaluation is completed, but no later than 4 weeks from the date of the referral.

Distribution: WHITE – send to audiologist, YELLOW – give to parents, GREEN – send to Utah Department of Health, PINK- file in medical record.

Results of Diagnostic Audiological Evaluation

Results of audiologic diagnostic evaluation for _____DOB_____
(Name of Child)

Procedure: ABR ☐ A-ABR ☐ TEOAE ☐ DPOAE ☐ Behavioral ☐

	Right Ear	Left Ear
Normal Hearing	☐	☐
Fluctuating Conductive Loss	☐	☐
Permanent Conductive Loss	☐	☐
Sensorineural Loss	☐	☐
DEGREE		
Mild	☐	☐
Moderate	☐	☐
Severe	☐	☐
Profound	☐	☐

OTHER _____

Date of Evaluation: _____ Diagnosis Complete? Yes ☐ Further testing needed ☐

Diagnostic Evaluation Report Attached: ☐ Yes ☐ No

Comments:

_____
Signature of Audiologist

_____
Address

_____
Address

_____
Phone

Please return form when initial diagnostic audiological evaluation is completed to:

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Hearing, Speech & Vision Services
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Salt Lake City, UT 84114-4620
Phone: 801-584-8215