Physician/Hearing Specialist Report

Child's Name: DOB:

Address: Age:

Grade:

School:

Results of Threshold Hearing Tests

	RIGHT EAR						LEFT EAR						
DATE OF EXAM	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000	PASS (P) OR FAIL (F)

Physician's Audiogram Attached? _____Yes _____No

Tentative Diagnosis: _____

Type of Hearing Loss: _____

Prognosis: _____

_____

_____

_____

Recommendations: _____

_____

_____

_____
(Physician's Signature) (Date)

_____
(Address)

_____
(Telephone)

_____
(Parent's Signature) (Date)

_____
(Address)

_____
(Telephone)