

PHYSICIAN/HEARING SPECIALIST REPORT

Child's Name: _____

Age: _____

Address: _____

Grade: _____

School: _____

Results of Threshold Hearing Tests

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

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)