IOWA Health and Human Services

Early Childhood OAE Screening Form

Program _____ **Child's Name** _____

Mother's Maiden Name _____

Address _____

Child Information

Child's ID #: _____ **Date of Birth:** (____/____/____)

☐ **Male** ☐ **Female** **Birthing Hospital:** _____

Screened for hearing loss at birth? ☐ Unknown ☐ Not screened ☐ Passed ☐ Referred

Children's Hearing Outcomes

Screener's Name: _____

Child's LEFT Ear

Visual Inspection

☐ *Refer* — **Date** (___/___/___)

☐ *Pass*

Consult health care provider; conduct OAE screening after medical clearance

1st OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

2nd OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
Middle Ear Consultation
(by health care provider)

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed.

Notes:

Child's RIGHT Ear

Visual Inspection

☐ *Refer* — **Date** (___/___/___)

☐ *Pass*

Consult health care provider; conduct OAE screening after medical clearance

1st OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

2nd OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
Middle Ear Consultation
(by health care provider)

Record outcomes on the **Diagnostic Follow-up Form**. After medical clearance, conduct an OAE Rescreen and refer for Audiological Evaluation (by a pediatric audiologist) if needed.

Notes:

Time Data

Approximate total time with child required for screening (in minutes):

1st OAE _____ **2nd OAE** _____

Machine # _____ Machine # _____