OAE Hearing Screening Form

Child's Name________________________________

Child Information

Date of Birth: (____/____/____)

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

Hearing Screening Outcomes

Screener's Name: ________________________________

Child's LEFT Ear

Visual Inspection

☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance

☐ *Pass*

1st OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

2nd OAE (___/___/___)

☐ *Can't test**
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
Middle Ear Consultation
(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)

Notes:

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Child's RIGHT Ear

Visual Inspection

☐ *Refer* — **Date** (___/___/___) → Consult health care provider; conduct OAE screening after medical clearance

☐ *Pass*

1st OAE (___/___/___)

☐ *Can't test*
☐ *Refer*
☐ *Pass*

2nd OAE (___/___/___)

☐ *Can't test**
☐ *Refer*
☐ *Pass*

Schedule follow-up (___/___/___)
Middle Ear Consultation
(by health care provider or *refer directly to a pediatric audiologist if child cannot be screened)

Notes:

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