EAST STROUDSBURG AREA SCHOOL DISTRICT
East Stroudsburg, Pennsylvania 18301

HEARING REFERRAL TO PRIVATE PHYSICIAN

Student Name_____ Grade/Teacher_____

Date_____

Dear Parent/Guardian:

Your child did not pass the hearing test given at his/her school.

RESULTS OF THRESHOLD HEARING TESTS

RIGHT EAR

Date of Exam	250	500	1000	2000	4000	8000	Pass (P) or Fail (F)

LEFT EAR

250	500	1000	2000	4000	8000	Pass (P) or Fail(F)

The hearing test given in the school is a screening test. Failure of this hearing screening test indicates only that your son/daughter should have a more complete ear examination.

It is recommended that he/she have a complete diagnostic ear examination by a physician. This is to include an audiogram.

Please take this form to the physician and request that the reverse side be completed. Kindly **return this completed form to the school nurse.**

Thank you for your cooperation.

Sincerely,

Comments:

School Nurse

School Nurse _____

School: _____

Address: _____

_____ Telephone No. ( )_____

MUST BE RETURNED TO THE SCHOOL NURSE

PHYSICIAN'S REPORT OF HEARING EVALUATION

Student Name_____ Date of Birth_____

Examination Date_____

RESULTS OF THRESHOLD HEARING TESTS

RIGHT EAR							LEFT EAR						
250	500	1000	2000	4000	8000	Pass (P) or Fail (F)	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_____

Physician's Name (Printed):_____

Address: _____

_____

Telephone No. (___)_____