Washington School District

School Nurse Department
201 Allison Avenue
Washington, PA 15301
Phone 724-223-5087 Fax 724-223-5045

HEARING SCREENING REFERRAL

Name _____ Age ___ Sex ____
Address _____
Grade ____ Teacher _____

Dear Parent/Guardian:

_____ DID NOT PASS the hearing test given at Washington Jr/Sr High School on _____.

Results of Threshold Hearing Tests

Exam Date	RIGHT EAR						LEFT EAR						Pass/ Fail
	250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000	

The hearing test, as given in the school, is a screening test. Failure of this hearing screening test indicates only that your child 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 request that the physician complete the other side of this letter. You are requested to sign and return this completed form to me as soon as possible.

If you have any questions, please do not hesitate to call. Thank you in advance for your prompt reply.

Ashley Brand, RN, BSN, CSN
Certified School Nurse
Washington Jr/Sr High School

Washington School District

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PHYSICIAN/HEARING SPECIALIST REPORT

Child's Name _____ Age _____
Address _____ Grade _____
_____
School Washington Jr/Sr High School

Results of Threshold Hearing Tests

Exam Date	RIGHT EAR						LEFT EAR						Pass/ Fail
	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/Guardian Signature

_____
Address

_____
Telephone