

**Wyoming Early Hearing Detection and Intervention (EHDI) Program  
Hearing/Vision Screening Results Form**

**\*Información Requerida**

**Nombre de el/la niño/a:** \_\_\_\_\_ **Fecha de nacimiento:** \_\_\_\_\_ **Sexo:** \* M \_\_\_ F \_\_\_

Lugar de evaluación: \_\_\_\_\_

Padres/Cuidadores: \_\_\_\_\_

Teléfono: \_\_\_\_\_

Dirección de los Padres/Cuidadores: \_\_\_\_\_

Médico de el/la niño/a: \_\_\_\_\_ Permiso para enviar resultados al médico: Sí \_\_\_ No \_\_\_

Si es necesario, permiso para reevaluar la audición de el/la niño/a: Sí \_\_\_ No \_\_\_

LEGEND
DNT = Did Not Test (e.g. < 9 months for immittance)
CNT = Could Not Test (e.g. behavior/sensitivity to task)
CNC = Could Not Condition (e.g. did not understand pure tone listening game)
MEP = Middle Ear Pressure
TM COMP = Tympanic membrane compliance
ECV = Ear canal volume (physical size)

1. Hearing Screening Results:												2. Vision Screening Results			3. Tracking			Notes								
Screen Date	Ear	Otosopic	IMMITTANCE				PURE TONES			OAE	Pass (P) / Fail (F)	Follow-up Recommendations (use I: 1-6, See below)	Follow-up to referral. Include date (use II: 1-13, See below)	Screener's Initials	Audiologist/Reviewer's Initials	Appearance of Eyes	Pass (P) / Fail (F)		Camera	Pass (P) / Fail (F)	Recommendation (use III: 1-5, see below)	Hearing Results Entered into EHDI	Vision Results Entered into EHDI database	Results Entered into MDT record		
			ECV	TM COMP	MEP	Acoustic Reflex	1,000 Hz	2,000 Hz	4,000 Hz																	
	R																									
	L																									
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**I. Follow-up Recommendations:**  
(Please choose one based on hearing screening results)

- Rescreen in 12 months unless concerns arise or a change in hearing is noted.  
Hearing levels appear adequate for speech/language development at this time.
- Rescreen in 3 months to monitor pressure equalization (PE) tubes. Hearing levels appear development at this time.
- Rescreen in 4-6 weeks.
- Refer to Primary Care Physician (PCP) and rescreen in 4-6 weeks.
- Refer to Ear Nose and Throat (ENT) physician and rescreen in 4-6 weeks.
- Refer to Audiologist and rescreen in 4-6 weeks.

**II. Follow-up to Medical and/or Audiological Referral:**  
(Please choose one for each referral made)

- Physician confirmed medical condition.
- Physician did not confirm medical condition.
- Audiologist confirmed hearing loss (conductive, SNHL, mixed).
- Audiologist reports hearing within normal limits at all frequencies.
- Pressure equalization tubes placed.
- Per parent report, medical referral has not been acted upon. Child has not been seen by doctor.
- Per parent report, audiological referral has not been acted upon. Child has not been seen by audiologist.
- Per parent report, medical appointment/follow-up is scheduled, but pending.
- Per parent report, audiological appointment/follow-up is scheduled, but pending.
- Phone call to parent. No answer. Left message asking them to call.
- Phone call to parent. No answer. Did not leave message.
- Letter sent to parent.
- Other \_\_\_\_\_

**III. Vision Follow-up Recommendations:**  
(Please choose one based on vision screening results)

- Passed both eyes, rescreen in 12 months.
- Child not screened due to corrective lenses.
- Refer to Eye Care Professional.
- Rescreen in \_\_\_ months.
- Other: \_\_\_\_\_

**IV. Factores de riesgo para la pérdida auditiva de inicio tardío, No presente/No señaló al nacer: (marque todas las que apliquen)**

- 1. Preocupación de los padres o cuidadores con respecto a la audición, el habla, el lenguaje y/o el retraso en el desarrollo
- 2. Síndromes asociados con la pérdida auditiva progresiva, como Neurofibromatosis, Osteopetrosis, y Usher's Syndrome
- 3. Trauma de la cabeza
- 4. Medicamentos ototóxicos
- 5. Recurrente o persistente Otitis Media con efusión durante 3 meses al menos
- 6. Exposición a altos niveles de ruido
- 7. Otro: \_\_\_\_\_
- 8. Ninguno

**V. Estado de la intervención temprana**

IFSP     IEP     Referido para evaluación del desarrollo     No hay intervención temprana en este momento

Fecha de IFSP/IEP inicial (si procede): \_\_\_\_\_

Fecha de IFSP/IEP revisión anual (si procede): \_\_\_\_\_

Otra: \_\_\_\_\_

**VI. Pérdida auditiva conocida**

No  
 Sí             Audífono(s)     BAHA(s)     Implante coclear(s)     Otra \_\_\_\_\_

**VII. Notas:** \_\_\_\_\_

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