State of Illinois
Illinois Department of Public Health

Early Hearing Detection and Intervention Audiological Evaluation Report

Child's Name _____ Med. ID _____

Other names this infant may also be known as:

_____

Date of Birth _____ Sex: ❑ Male ❑ Female

Birth Hospital _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

_____
(City) (State) (ZIP) (County) (Phone)

Infant's Primary Health Care Provider _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Audiologist Full Name _____

Facility / Agency _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Is there family history of permanent childhood hearing loss? ❑ Yes ❑ No

List any known risk factors
for hearing impairment:

NOTES

Audiological Evaluation Report (Cont.)

Child's Name _____ Date of Birth _____

Date of this Diagnostic Evaluation _____

Diagnostic Tests (mark all that apply)

- ❑ DPOAE
- ❑ TEOAE
- ❑ ABR Click ❑ Tone Burst
- ❑ ASSR
- ❑ Tympanometry 1000Hz ❑ 226Hz
- ❑ Physical exam and/or review of medical records
- Other (Specify)

Diagnosis/Type of Loss	Right	Left
Hearing within Normal Limits		
Sensorineural Loss		
Permanent Conductive Loss		
Mixed Loss		
Undetermined Type Loss		

Degree of Loss	Right	Left
Mild (26-40dB)		
Moderate (41-55dB)		
Moderately Severe (56-70dB)		
Severe (71-90dB)		
Profound (91+dB)		
Sloping (describe)		

Recommendations / Referrals	Date of Referral/Appointment
Early Intervention Services (EI)	
Division Of Specialized Care For Children (DSCC)	
Medical Referral (to whom?)	
Hearing Instrument Evaluation	
Other (specify)	

This form is required to adequately document results.
More specific evaluation information may be submitted in addition, if desired.
Submit BOTH PAGES of this form to:

Illinois Department of Public Health
Early Hearing Detection and Intervention
535 W. Jefferson St., 2nd floor
Springfield, IL 62761
217-782-3300

This form may be faxed to: 217-524-4201
OR
E-mailed to: ***dph.hearingreports@illinois.gov***