

Early Hearing Detection and Intervention Program
 Commission for Children with Special Health Care Needs
 310 Whittington Parkway, Suite 200
 Louisville, KY 40222
 502-429-4430 or 1-877-757-4327
 FAX 502-429-4489

Audiology Update Form (AUF)
Worksheet
 Please Print or Type Information

Please complete this form on every child referred based on a hospital screening and each infant or child diagnosed with a permanent hearing loss, regardless of newborn hearing status (up to age 3 years of age).
 Please fax forms to the EHDI office at 502-429-4489.

Audiologist/Provider:		Today's Date:									
Facility Name and Address:											
Patient:		Date of Birth:									
Infant name change since discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, previous name:		Parent or Guardian Name: Street Address: City: State: Zip Code: Phone:									
Primary Care Provider:		Birth Hospital:									
Last Hearing Screen:											
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Left Ear</td> <td style="width: 15%;"><input type="checkbox"/> Passed</td> <td style="width: 15%;"><input type="checkbox"/> Referred</td> <td style="width: 55%;"></td> </tr> <tr> <td>Right Ear</td> <td><input type="checkbox"/> Passed</td> <td><input type="checkbox"/> Referred</td> <td></td> </tr> </table>				Left Ear	<input type="checkbox"/> Passed	<input type="checkbox"/> Referred		Right Ear	<input type="checkbox"/> Passed	<input type="checkbox"/> Referred	
Left Ear	<input type="checkbox"/> Passed	<input type="checkbox"/> Referred									
Right Ear	<input type="checkbox"/> Passed	<input type="checkbox"/> Referred									

Hearing Follow-up

Date of Testing _____ (mm/dd/yyyy)

Permanent Childhood Hearing Loss (PCHL) Yes <input type="checkbox"/> No <input type="checkbox"/>	Left Ear <input type="checkbox"/> Normal <input type="checkbox"/> Mild (20-40 dB) Sensorineural HL <input type="checkbox"/> Mild Conductive HL <input type="checkbox"/> Mild Mixed HL <input type="checkbox"/> Moderate (40-60 dB) Sensorineural HL <input type="checkbox"/> Moderate Conductive HL <input type="checkbox"/> Moderate Mixed HL <input type="checkbox"/> Severe (60-90) Sensorineural HL <input type="checkbox"/> Severe Conductive HL <input type="checkbox"/> Severe Mixed HL <input type="checkbox"/> Severe To Profound HL <input type="checkbox"/> Severe To Profound Sensorineural HL <input type="checkbox"/> Severe To Profound Mixed HL <input type="checkbox"/> Profound (>90dB) Sensorineural HL <input type="checkbox"/> Profound Mixed <input type="checkbox"/> Auditory Dys-Synchrony <input type="checkbox"/> Mild to Moderate Sloping <input type="checkbox"/> Mild to Severe Sloping <input type="checkbox"/> Mild to Profound Sloping <input type="checkbox"/> Moderate to Severe Sloping <input type="checkbox"/> Moderate to Profound Sloping <input type="checkbox"/> Reverse Sloping <input type="checkbox"/> Inconclusive - Testing Completed* <input type="checkbox"/> Inconclusive - Unable to Test* <input type="checkbox"/> Inconclusive - Sound Field Only* <input type="checkbox"/> Inconclusive - Speech Results Only* <input type="checkbox"/> Inconclusive - Medical Referral Required	Right Ear <input type="checkbox"/> Normal <input type="checkbox"/> Mild (20-40 dB) Sensorineural HL <input type="checkbox"/> Mild Conductive HL <input type="checkbox"/> Mild Mixed HL <input type="checkbox"/> Moderate (40-60 dB) Sensorineural HL <input type="checkbox"/> Moderate Conductive HL <input type="checkbox"/> Moderate Mixed HL <input type="checkbox"/> Severe (60-90) Sensorineural HL <input type="checkbox"/> Severe Conductive HL <input type="checkbox"/> Severe Mixed HL <input type="checkbox"/> Severe To Profound HL <input type="checkbox"/> Severe To Profound Sensorineural HL <input type="checkbox"/> Severe To Profound Mixed HL <input type="checkbox"/> Profound (>90dB) Sensorineural HL <input type="checkbox"/> Profound Mixed <input type="checkbox"/> Auditory Dys-Synchrony <input type="checkbox"/> Mild to Moderate Sloping <input type="checkbox"/> Mild to Severe Sloping <input type="checkbox"/> Mild to Profound Sloping <input type="checkbox"/> Moderate to Severe Sloping <input type="checkbox"/> Moderate to Profound Sloping <input type="checkbox"/> Reverse Sloping <input type="checkbox"/> Inconclusive - Testing Completed* <input type="checkbox"/> Inconclusive - Unable to Test* <input type="checkbox"/> Inconclusive - Sound Field Only* <input type="checkbox"/> Inconclusive - Speech Results Only* <input type="checkbox"/> Inconclusive - Medical Referral Required
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*Further Testing Required

Type of Testing	
AABR <input type="checkbox"/>	
ABR <input type="checkbox"/> (if checked, select one of the following) <input type="checkbox"/> Click Only <input type="checkbox"/> Frequency specific <input type="checkbox"/> Clicks and Frequency Specific	
OAE <input type="checkbox"/> (if checked, select one of the following) <input type="checkbox"/> Screen <input type="checkbox"/> Diagnostic <input type="checkbox"/> Screen and Diagnostic	
Tympanometry <input type="checkbox"/> (if checked, select one of the following) <input type="checkbox"/> 226Hz <input type="checkbox"/> 1000 Hz <input type="checkbox"/> Multi Frequency	
Acoustic Reflexes <input type="checkbox"/> (if checked, select one of the following) <input type="checkbox"/> Screen <input type="checkbox"/> Diagnostic	
Behavioral Testing <input type="checkbox"/> (if checked, select one of the following) <input type="checkbox"/> BOA <input type="checkbox"/> VRA <input type="checkbox"/> Conditioned Play Audiometry	
Pure Tone Air <input type="checkbox"/>	
Bone <input type="checkbox"/>	
Sound Field <input type="checkbox"/>	
Ear Specific <input type="checkbox"/>	

Recommendations and Referrals			
Recommendations	<input type="checkbox"/> Audiological follow-up. (if checked, enter date) (mm/yy) _____		
	Loaners fit _____(mm/yy)		
	Personal Amplification Fit _____(mm/yy)		
	Assistive listening device _____(mm/yy)		
	Declined amplification _____(mm/yy)		
Cochlear implant _____(mm/yy)			
Referrals (Replaces medical referrals)	Select all referrals from the Specialty List:		
	<input type="checkbox"/> Allergy & Immunology <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Cardiovascular Surgery <input type="checkbox"/> Dermatology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Endocrinology <input type="checkbox"/> Endodontia <input type="checkbox"/> Family Practice <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General Practice <input type="checkbox"/> Genetics <input type="checkbox"/> Hand Surgery <input type="checkbox"/> Hematology <input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Internal Medicine <input type="checkbox"/> Neonatology <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurological Surgery <input type="checkbox"/> Neurology <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Oncology <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Optometry <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthodontia <input type="checkbox"/> Orthopedics <input type="checkbox"/> Osteopathic <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Otorhinolaryngology <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics	<input type="checkbox"/> Pedodontia <input type="checkbox"/> Periodontia <input type="checkbox"/> Physiatry <input type="checkbox"/> Physical Medicine & Rehab <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Prosthodontia <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychology <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Radiology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Surgery <input type="checkbox"/> Thoracic Surgery <input type="checkbox"/> Urology Other:

Early Intervention (Replaces First Steps)	<input type="checkbox"/> Part C (First Steps):	Date Referred _____(mm/yy)
	<input type="checkbox"/> Referred <input type="checkbox"/> Not Referred <input type="checkbox"/> Currently Enrolled in Services.	Date Enrolled _____(mm/yy)
	<input type="checkbox"/> Other Private/Independent Therapist:	Date Referred _____(mm/yy)
	<input type="checkbox"/> Referred <input type="checkbox"/> Not Referred <input type="checkbox"/> Currently Enrolled in Services.	Date Enrolled _____(mm/yy)

Results and Recommendations

Signature: _____