

Early Hearing Detection and Intervention Program

Office 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 502-429-7160.

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: (If reported that one ear referred, mark referred – as both ears should be re-tested.)									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Left Ear</td> <td style="padding: 2px;"><input type="checkbox"/> Passed</td> <td style="padding: 2px;"><input type="checkbox"/> Referred</td> </tr> <tr> <td style="padding: 2px;">Right Ear</td> <td style="padding: 2px;"><input type="checkbox"/> Passed</td> <td style="padding: 2px;"><input type="checkbox"/> Referred</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"/> Cannot be determined at this time <input type="checkbox"/> Comment:	Left Ear <u>Degree of Hearing Loss</u> <input type="checkbox"/> Normal (-10 to 15 dB) <input type="checkbox"/> Referred <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB) <input type="checkbox"/> Inconclusive - Further Testing Required* <input type="checkbox"/> Inconclusive - Medical Referral Required <u>Type of Hearing Loss</u> <input type="checkbox"/> Conductive <input type="checkbox"/> Sensorineural <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Dys-Synchrony <u>Configuration of Hearing Loss</u> <input type="checkbox"/> Cookie Bite <input type="checkbox"/> Flat <input type="checkbox"/> High Frequency <input type="checkbox"/> Reverse Sloping <input type="checkbox"/> Sloping <u>Best Sensitivity</u> <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB) <u>Worst Sensitivity</u> <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB)	Right Ear <u>Degree of Hearing Loss</u> <input type="checkbox"/> Normal (-10 to 15 dB) <input type="checkbox"/> Referred <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB) <input type="checkbox"/> Inconclusive - Further Testing Required* <input type="checkbox"/> Inconclusive - Medical Referral Required <u>Type of Hearing Loss</u> <input type="checkbox"/> Conductive <input type="checkbox"/> Sensorineural <input type="checkbox"/> Mixed <input type="checkbox"/> Auditory Dys-Synchrony <u>Configuration of Hearing Loss</u> <input type="checkbox"/> Cookie Bite <input type="checkbox"/> Flat <input type="checkbox"/> High Frequency <input type="checkbox"/> Reverse Sloping <input type="checkbox"/> Sloping <u>Best Sensitivity</u> <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB) <u>Worst Sensitivity</u> <input type="checkbox"/> Slight Hearing Loss (16 – 25 dB) <input type="checkbox"/> Mild (26 - 40 dB) <input type="checkbox"/> Moderate (41 - 55 dB) <input type="checkbox"/> Moderately Severe (56 – 70 dB) <input type="checkbox"/> Severe (71 – 90 dB) <input type="checkbox"/> Profound (>90 dB)
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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)
Hearing Aids Recommended <input type="checkbox"/>	

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

Signature: _____