DEPARTMENT OF HEALTH

Hearing Referral Letter

Child's Name: _____

Date of Birth: _____

Dear Parent/Guardian:

In keeping with the recommendations of the Minnesota Department of Health for conducting hearing screening in a school setting, your child's hearing was screened on _____/_____/_____ and rescreened on_____/_____/_____. The results of the screen and rescreen are detailed in the grid below.

- Your child did not respond to all of the sounds on their hearing screening.
- These results mean your child may have a hearing problem.
- Please take him/her to your medical clinic and/or audiologist for further hearing evaluation. If your child is already receiving care for hearing problems or if you need assistance in finding a health care provider, please contact the school nurse.
- Bring this letter with you when your child is evaluated and ask the health care provider to fill out the back side of this form.
- **RETURN THIS FORM TO THE SCHOOL NURSE WITH THE HEALTH CARE PROVIDER'S EVALUATION COMMENTS ON THE BACK SIDE OF THIS LETTER.**

Pure Tone Audiometry – Right Ear	Initial Screen	Rescreen
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER
Pure Tone Audiometry – Left Ear	**Initial Screen**	**Rescreen**
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER

Health Care Provider

Please complete the back side of this form and return to parent/guardian or to the school nurse.

School Nurse: _____ Phone: _____

School: _____ Fax: _____

Address: _____

Health Care Provider Evaluation

Name/Title of Provider: _____ Phone: _____

Date of Exam: _____ Fax: _____

Clinic Name/ Location: _____

I have examined (name) _____ and find the following:

MEDICAL:

- ☐ Hearing (circle): PASS or REFER
- ☐ Medically treatable
- ☐ Not medically treatable
- ☐ Outer Ear
- ☐ Middle Ear
- ☐ Inner Ear
- ☐ Refer to Audiology

Further Comments: _____

_____

_____

Recommendations to support learning in the school environment: _____

_____

_____

Signed: _____

Date: _____

AUDIOLOGICAL:

- ☐ Normal Hearing
- ☐ Conductive Hearing Loss
- ☐ Mixed Hearing Loss
- ☐ Sensorineural Hearing Loss
- ☐ Refer to Physician
- ☐ Amplification Evaluation

Further Comments: _____

_____

_____

Recommendations to support learning in the school environment: _____

_____

_____

Signed: _____

Date: _____

Parent/guardian, please return this completed form to the school nurse.

Minnesota Department of Health
Child and Teen Checkups
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

01/2022

To obtain this information in a different format, call: 651-201-3650.