Northwest Regional Education Service District - Washington Service Center
5825 NE Ray Circle • Hillsboro, Oregon 97124 • (503) 690-5446

HEARING TEST RECORD

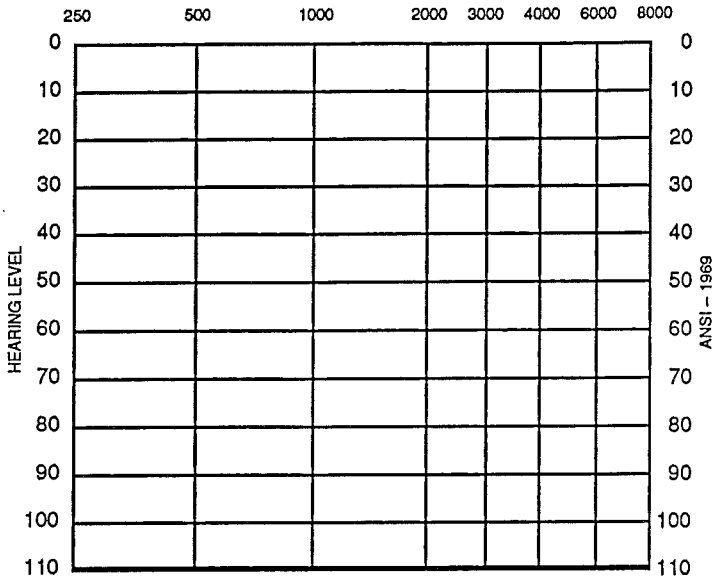
Name: _____ Birth Date: _____ M F Grade: _____

School: _____ District: _____

Parent's Name: _____ Phone: _____(Hm.) _____(Wk.)

Address: _____ City: _____

AUDIOGRAM

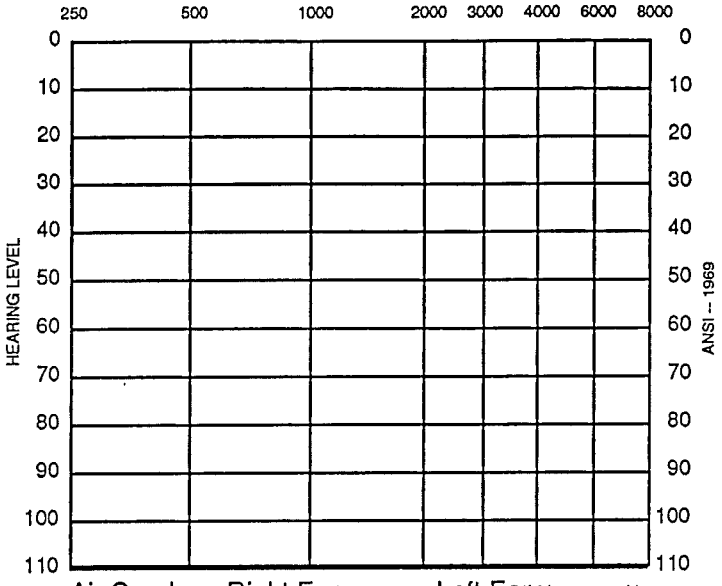


Air Cond: Right Ear o—o Left Ear x- - - - -x
Bone Cond: Right Ear [Left Ear]

Notes: _____

Date: _____ Examiner: _____

AUDIOGRAM



Air Cond: Right Ear o—o Left Ear x- - - - -x
Bone Cond: Right Ear [Left Ear]

Notes: _____

Date: _____ Examiner: _____

Tympanometry

	COMP	MEP	VOL
Right _____	R ____	____	____
Left _____	L ____	____	____

Acoustic Reflex

Right _____

Left _____

Known permanent hearing loss?

No_____

Yes_____ Aided _____

Medical treatment or previous ear disease: _____

_____

_____

Suggestions and Comments

- ☐ Hearing test results are within normal limits.
- ☐ Medical referral for wax removal is suggested.
- ☐ Medical referral suggested to rule out possible middle-ear problem.
- ☐ Medical referral is suggested to rule out possible sensorineural hearing loss.

Other: _____

If you decide to have further medical attention, please have your health care provider complete the following and return a copy to our office.

PHYSICIAN'S REPORT OF EAR, NOSE AND THROAT EXAMINATION

Diagnosis and Recommendations: _____

_____

_____

Examining Physician's Signature: _____ Date: _____

Examining Physician's Name: _____

(Please type or print)