Head Start Hearing Screening (0-3 years)
SECOND VISIT

Child's Name: _____ **Family Advocate/HS Site:** _____
(Last name, first name)

Date: _____ **Tester:** _____ **Child's Date of Birth**: _____

1. **Is there drainage from either ear?** …….. Yes No
   If no, proceed to step 2. If yes, refer to a physician and reschedule screening.

2. **Otoacoustic Emission (OAE) Measures:**
   On the date of the 1st screening, child (circle)**:**
   - Passed / Referred in Right Ear
   - Passed / Referred in Left Ear
   - Could not be tested (noise, child refused, etc.)

   Right ear OAEs present…… Pass Refer DNT CNT
   Left ear OAEs present…….. Pass Refer DNT CNT

3. **Tympanometry ****To be completed by UWSHC only

Maico EZ Tymp

Volume (ml)	Compliance (ml)	Pressure (daPa)	
	*		Right Ear
	*		Left Ear

   - **Right middle ear function**…… Normal Abnormal DNT
   - **Left middle ear function**…….. Normal Abnormal DNT

4. **Follow-up**
   - **Refer to physician and retest** (Absent OAEs & Abnormal Tymps or excessive wax) _____
   - **Refer for diagnostic testing** (Absent OAEs, Normal Tymps) _____
   - **Pass** (Pass OAEs for BOTH EARS) _____