south dakota
BIRTH TO THREE
The first three years build a lifetime

SCREENING RESULTS REPORT

Child's name _____ _____ _____ DOB ____/_____/_____
First Middle Last

Parent's name _____ Phone _ _____

Address _ _____

Date of screen _____ Name of screener _____

Name of screening tools used _ _____

Results of OAE Hearing Screening (P = Pass, R = Refer) _____Right Ear _____Left Ear

The screening resulted in the following recommendation:

_____ Referral to a diagnostic audiologist; Audiologist/Clinic_____ City_____

_____ Referral for multidisciplinary evaluation including audio logical testing
Proposed date of evaluation if this choice is selected: _____
(date)

_____ Referral for multidisciplinary evaluation. No audio logical testing needed.
Proposed date of evaluation if this choice is selected: _____
(date)

_____ Referral to other resources

_____ Re-screen recommended in ____0,_____1,_____2,_____3,_____4, _____5,_____6 months

_____ No further action is needed

_____ Other (please explain)

Comments _____
_____

Date screening results shared with parent: _____
(must be within 5 working days)

_____ _____
Parent Signature Screener Signature

Date screening results shared with initial service coordinator: _____
(must be within 5 working days)

_____ _____
Initial Service Coordinator Signature Date Received