Agency Program: ___________________________ KIDS Child ID# _______________________

Child’s Legal First Name __________________ Legal Last Name _______________________

1. Date Hearing Screen Completed: __/__/____ MM/DD/YYYY

2. Screening Location:
   ○ Child’s Home
   ○ School District or Agency Building
   ○ Other ______________________________________

3. Screening Equipment:
   ○ OAE (Otoacoustic Emission Testing)
   ○ ABR (Automated Auditory Brain Stem Response)
   ○ Other ________________________________

   Left Ear Screening Results: Right Ear Screening Results:
   ○ Passed ○ Passed
   ○ Failed ○ Failed
   ○ Inconclusive ○ Inconclusive

4. As a result of this hearing screening, was a recommendation for further assessment or services provided to the parent(s)? (If yes, complete question #5)
   ○ Yes ○ No

5. If yes in question 4, did the family access recommended services for this child? (If no, complete #6)
   ○ Yes ○ No

6. If no in question 5, check all of the following that apply:
   ○ Family declined further services.
   ○ Family opts out for religious or other medical reasons.
   ○ Family lacks access to services (i.e. distance for treatment, lack of transportation, etc.)
   ○ Additional testing is cost prohibitive.
   ○ Other ____________________________________________________