Programs for Infants and Children
Hearing Screen

Child Name_____ DOB_____ Date of Screening _____

Was the child's hearing screened as a newborn? Yes ____ No ____ Unknown ____
Results of the testing/screening: _____

If yes, has the child's hearing been tested or screened since birth? Yes ____ No ____ Unknown ____
Results of the testing/screening: _____

<u>Hearing Development Milestones Checklist</u>

Birth to 3 Months:

Yes No

___ ___ Does child startle, awaken or cry at loud sounds?
___ ___ Does child turn to you when you speak?
___ ___ Does child smile when spoken to?
___ ___ Does your child seem to recognize your voice and quiet down if crying?

4 to 6 Months:

___ ___ Does child respond to "No", or changes in your tone of voice?
___ ___ Does child look around for the source of new sounds: the door bell, vacuum, barking?
___ ___ Does child notice toys that make sounds?

7 Months to1 Year:

___ ___ Does child recognize words for items like "cup", "shoe", "juice"?
___ ___ Does child respond to requests like "Come here" or "Want more"?
___ ___ Does your child enjoy games like peek-a-boo or pat-a-cake?
___ ___ Does your child turn or look up when you call his or her name?

1 to 2 Years:

___ ___ Can child point to pictures in a book when they are named?
___ ___ Does child point to a few body parts when asked?
___ ___ Can child follow simple commands and understand simple questions such as : "Roll the ball," "Kiss the baby," "Where's your shoe?"

2 to 3 Years:

___ ___ Does child continue to notice sounds (telephone ringing, television sounds or knocking at the door)?
___ ___ Can your child follow two requests like: "Get the ball," or "Put it on the table"

Risk Indicators:

YES NO

____ ____1. Does the Hearing Development checklist above indicate (any NO answers) that the child has not met hearing milestones?
____ ____ 2. Does parent have a concern about child's hearing, speech, language or other development delay?

YES NO

____ ____ 3. Has child had otitis media (infection of the middle ear) lasting more than 3 months?
If yes, were tubes placed? Yes ___ No ___
If yes, when? _____Are they in place now? Yes ___ No ___

____ ____ 4. During pregnancy, was child exposed to:
Toxoplasmosis❑ Syphilis❑ Rubella ❑ Cytomegalovirus ❑ Herpes❑

____ ____ 5. As a newborn, did child have an illness/condition requiring 48 hours or more in the NICU?
Describe: _____

____ ____ 6. Has child had bacterial meningitis (or other infections) associated with hearing loss?
If yes, at what age? _____ Hearing testing since then? _____

____ ____ 7. As a newborn, did child need an exchange transfusion because of hyperbilirubinemia, or have the need for mechanical ventilation, or conditions requiring ECMO?
Explain: _____

____ ____ 8. Does child have any atypical features of the outer ear, ear canal, mouth, nose, neck or head?
Describe: _____

____ ____9. Is there a family history of permanent hearing loss before the age of 5?
Describe _____

____ ____ 10. Does child have a diagnosis of a syndrome or condition known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction?
Describe: _____

____ ____ 11. Has your child been diagnosed as having any syndromes associated with progressive hearing loss such as Down, Usher, Waardenburg; a neurodegenerative disorder such as Hunter syndrome; or sensory and/or motor neuropathies such as Friedreich's ataxia or Charcot-Maire-Tooth Syndrome?
Explain: _____

____ ____ 12. Has child ever had any head trauma? Describe: _____

<u>Scoring</u>

Tally only questions 1 through 12 of the Risk Indicators section. A Pass score is indicated by all "NO" responses. If the child has one or more "YES" responses, a Refer score is indicated.

Screen Result check (✓): ❑Pass : ❑ Refer

Referred to: ___OAE Screen Date: _____

___Refer to physician Date: _____
___Audiology Evaluation Date: _____