

Hearing Referral Letter

Child's Name:	Date of Birth:
Dear Parent/Guardian:	
Our school provides hearing screening usin Department of Health. Your child's hearing on/	g the guidelines developed by Minnesota was screened on/and repeated
 Your child did not respond to all the soubelow. 	unds on their hearing screening. Refer to the chart

Pure Tone Audiometry – Right Ear	Initial Screen	Rescreen
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER
Pure Tone Audiometry – Left Ear	Initial Screen	Rescreen
500 Hz, 25 dB	PASS/REFER	PASS/REFER
500 Hz, 25 dB 1000 Hz, 20 dB		111 11
	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER PASS/REFER	PASS/REFER PASS/REFER

- These results mean your child may have trouble hearing.
- Please take your child to your clinic and/or audiologist (hearing specialist) to check their hearing.
- If your child is already receiving care for hearing problems or if you need help finding a health care provider, please tell the school nurse.
- Please give this letter with the school hearing results to the clinic and/or audiologist who is doing the hearing check.
- If you have questions or need connecting with a clinic, please contact us.

HEARING REFFERAL LETTER

Child's Name: Date of Birth: School Name: Date of Birth: Date of Birth: Date of Birth: School Name: Date of Birth: Date of Birth: School Name: Date of Birth:	Health Care Provider, please complete this form.		
School Name:	Child's Name:	Date of Birth:	
Provider comments: have examined this child on/ and find the following: MEDICAL:			
have examined this child on			
MEDICAL: Hearing (circle): PASS or REFER Medically treatable Conductive Hearing Loss Mixed Hearing Loss Mixed Hearing Loss Mixed Hearing Loss Sensorineural Hearing Loss Middle Ear Middle Ear Inner Ear Refer to Audiology Further Comments: Further Comments: Recommendations to support learning in the school environment: Provider Name/Title: Contact Information: School Nurse Name: Phone: Phone:	Provider comments:		
Hearing (circle): PASS or REFER	I have examined this child on/	/ and find the following:	
Medically treatable Conductive Hearing Loss Mixed Hearing Loss Outer Ear Sensorineural Hearing Loss Refer to Physician Inner Ear Amplification Evaluation Further Comments: Further Commen	MEDICAL:	AUDIOLOGICAL:	
Not medically treatable Mixed Hearing Loss Sensorineural Hearing Loss Sensorineural Hearing Loss Refer to Physician Inner Ear Amplification Evaluation Amplification Evaluation Further Comments: Further Commen	☐ Hearing (circle): PASS or REFER	☐ Normal Hearing	
Outer Ear Sensorineural Hearing Loss Refer to Physician Amplification Evaluation Refer to Audiology Further Comments: Further Comments: Further Comments: Further Comments: Child should return for follow up examination on Provider Name/Title: Contact Information: Schools nurse or health staff fill out this section below before sending home. Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone: Please have: School or you can return this to:	☐ Medically treatable	☐ Conductive Hearing Loss	
Middle Ear	☐ Not medically treatable	☐ Mixed Hearing Loss	
Inner Ear	Outer Ear	☐ Sensorineural Hearing Loss	
Recommendations to support learning in the school environment: Child should return for follow up examination on Provider Name/Title: Contact Information: Schools nurse or health staff fill out this section below before sending home. Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone: Phone:	☐ Middle Ear	☐ Refer to Physician	
Recommendations to support learning in the school environment: Child should return for follow up examination on Provider Name/Title: Contact Information: Schools nurse or health staff fill out this section below before sending home. Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone: Phone:	☐ Inner Ear	☐ Amplification Evaluation	
Recommendations to support learning in the school environment:	☐ Refer to Audiology		
Recommendations to support learning in the school environment: Recommendations to support learning in the school environment: Provider Name/Title: Contact Information: Schools nurse or health staff fill out this section below before sending home. Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone: Phone:	Further Comments:	Further Comments:	
Schools nurse or health staff fill out this section below before sending home. Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone:	environment: Child should return for follow up examination of	Recommendations to support learning in the school environment:	
Please have the parent return this form to the school or you can return this to: School Nurse Name: Phone:	Contact Information:		
Phone:	Please have the parent return this form to the	e school or you can return this to:	

This templated form was developed by MDH for use in schools.

Minnesota Department of Health Child and Teen Checkups 651-201-3650 health.childteencheckups@state.mn.us www.health.state.mn.us

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To obtain this template in a different format, call: 651-201-3650.