DEPARTMENT OF HEALTH

Hearing Referral Letter

Child's Name: _____ Date of Birth: _____

Dear Parent/Guardian:

Our school provides hearing screening using the guidelines developed by Minnesota Department of Health. Your child's hearing was screened on _____/_____/____ and repeated on _____/_____/____.

- Your child did not respond to all the sounds on their hearing screening. Refer to the chart below.

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
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

- 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

Health Care Provider, please complete this form.

Child's Name: _____ Date of Birth: _____

School Name: _____

Provider comments:

I have examined this child on_____/_____/_____ and find the following:

MEDICAL:

- ☐ Hearing (circle): PASS or REFER
- ☐ Medically treatable
- ☐ Not medically treatable
- ☐ Outer Ear
- ☐ Middle Ear
- ☐ Inner Ear
- ☐ Refer to Audiology

Further Comments: _____

_____

_____

Recommendations to support learning in the school environment: _____

_____

_____

AUDIOLOGICAL:

- ☐ Normal Hearing
- ☐ Conductive Hearing Loss
- ☐ Mixed Hearing Loss
- ☐ Sensorineural Hearing Loss
- ☐ Refer to Physician
- ☐ Amplification Evaluation

Further Comments: _____

_____

_____

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: _____

Address: _____

_____

Email: _____

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

Minnesota Department of Health
Child and Teen Checkups
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To obtain this template in a different format, call: 651-201-3650.