Clarksville-Montgomery County School System
HEALTH SERVICES
HEARING REFERRAL
School year 20___ - 20___

Student Name _____ Date _____

Grade _____ Teacher _____

Dear Parent:
The results of the school hearing screening showed that your child may have some hearing difficulty. A follow up by your physician is indicated. The results of this examination will assist school personnel in making all necessary modifications to your child's educational program.

Screening done at 20dB HL

	Initial screening		Re-Screen	
Frequencies	Left Ear	Right Ear	Left Ear	Right Ear
1000 Hz	_____	_____	_____	_____
2000 Hz	_____	_____	_____	_____
4000 Hz	_____	_____	_____	_____

(X – Adequate Response NR – No Response)

_____
School Nurse

This form should be completed by the examining physician and returned to the school nurse.

Date of examination _____

Diagnosis _____

Examination Results

Frequency	Left Ear	Right Ear	Other Findings _____
1000 Hz	_____	_____	_____
2000 Hz	_____	_____	_____
4000 Hz	_____	_____	_____
_____	_____	_____	_____

Treatment given _____
_____

Recommendations _____
_____

Re-Evaluation is recommended in _____ months / _____ years

_____ _____
Physician Name (please print) Physician Signature

_____ _____
Address Date

_____ _____
City State Zip Telephone Number Fax Number