

Audiologic Diagnostic Checklist Birth-6 months

Indiana's Early Hearing Detection and Intervention Program

TEST	DATE	DEFERRED	INITIALS
<input type="checkbox"/> Case History			
<input type="checkbox"/> Otoscopic Exam			
Diagnostic ABR			
<input type="checkbox"/> Air Conduction Click Threshold			
<input type="checkbox"/> Cochlear Microphonic(Click Polarity)			
<input type="checkbox"/> Air Conduction low frequency tone burst: ___Hz			
<input type="checkbox"/> Air Conduction high frequency tone burst: ___Hz			
<input type="checkbox"/> Bone Conduction Click Threshold			
<input type="checkbox"/> Other: (ASSR)			
Diagnostic OAE			
<input type="checkbox"/> Transient Evoked OAE			
<input type="checkbox"/> Distortion Products OAE			
Immittance Measures			
<input type="checkbox"/> High Frequency Tympanometry: ___Hz			
<input type="checkbox"/> Middle Ear Muscle Reflexes			
<input type="checkbox"/> Behavioral Observation Audiometry or VRA (>5 months)			
<input type="checkbox"/> Discuss Recommendations with Family			
<input type="checkbox"/> Otologic Referral for Confirmed Loss			
<input type="checkbox"/> Referral/Recommendation for Vision Evaluation			
<input type="checkbox"/> Referral/Recommendation for Genetic Counseling			
<input type="checkbox"/> Referral to First Steps for Early Intervention			
<input type="checkbox"/> Report to Indiana State Department of Health			
<input type="checkbox"/> Report to Primary Medical Provider			
<input type="checkbox"/> Discuss Family Support Opportunities with Family			