Clarksville-Montgomery County School System
HEALTH SERVICES
HEARING REFERRAL

Student Name _____ Date _____

Grade _____ Teacher _____

Dear Parent:
Your child recently participated in a hearing screening mandated by the State of Tennessee. 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)

Date of examination _____ School Nurse _____

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

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 of Examination

_____ _____
City State Zip Telephone Number Fax Number