Children's Hearing Center
of East Tennessee

* John P. Little, M.D.
Board Certified
Fellowship Trained

ichael J. Belmont, M.D.
Board Certified
Fellowship Trained

R. Mark Ray, M.D.
Board Certified
Fellowship Trained

Kristie Johnston, Au.D.
CCC-A
Holly North, M.A.
CCC-A
Kristi Walden, Au.D.
Pediatric Audiologists

Samantha Wallenstein,
M.S.
Audiology Extern

Janet L. Harris
Office Manager

* Implant Surgeon,
Pediatric Cochlear
Implant Program
At Children's Hospital

Children's Hospital
Medical Office Building
2100 Clinch Avenue
Suite 410
Knoxville, TN 37916

865-521-6005
fax 865-521-6088

A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Medical Release

Patient:

Date of Birth:

Chart:

I hereby authorize Children's ENT Specialists to furnish and obtain information from insurance carriers and other health providers/facilities concerning my child's illness and treatments. Information may be furnished and obtained from the following:

Name of provider/facility	Location	Phone number

Printed Name of Parent	Signature of Parent	Date

Printed Name of Witness	Signature of Witness	Date

This request is valid for this release only

FISHER'S AUDITORY PROBLEMS CHECKLIST

Student Name _____ District/Building _____

Date _____ Grade _____ Observer _____ Position _____

Please place a check mark before each item that is considered to be a concern by the observer:

___ 1. Has a history of hearing loss.
___ 2. Has a history of ear infection(s).
___ 3. Does not pay attention (listen) to instruction 50% or more of the time.
___ 4. Does not listen carefully to directions - often necessary to repeat instructions.
___ 5. Says "Huh?" and "What?" at least five or more times per day.
___ 6. Cannot attend to auditory stimuli for more than a few seconds.
___ 7. Has a short attention span.
(if this item is checked, also check the most appropriate time frame.)
_____ 0-2 minutes _____ 5-15 minutes
_____ 2-5 minutes _____ 15-30 minutes
___ 8. Daydreams - attention drifts - not with it at times.
___ 9. Is easily distracted by background sound(s).
___ 10. Has difficulty with phonics.
___ 11. Experiences problems with sound discrimination.
___ 12. Forgets what is said in a few minutes.
___ 13. Does not remember simple routine things from day to day.
___ 14. Displays problems recalling what was heard last week, month, year.
___ 15. Has difficulty recalling a sequence that has been heard.
___ 16. Experiences difficulty following auditory directions.
___ 17. Frequently misunderstands what is said.
___ 18. Does not comprehend many words - verbal concepts for age/grade level.
___ 19. Learns poorly through the auditory channel.
___ 20. Has a language problem (morphology, syntax, vocabulary, phonology).
___ 21. Has an articulation (phonology) problem.
___ 22. Cannot always relate what is heard to what is seen.
___ 23. Lacks motivation to learn.
___ 24. Displays slow or delayed response to verbal stimuli.
___ 25. Demonstrates below average performance in one or more academic area(s).

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked _____ x 4 = _____.

Normative data - grade score from reverse side _____.

****This form must be completed in full. Please do not send charts, narratives, and/or diagrams as they will be returned****

Tennessee Department of Health
Newborn Screening Follow Up Program
1st Floor, R.S. Gass Building
630 Hart Lane, Nashville, Tennessee 37243
Phone (855) 202-1357 Fax (615) 532-8555

Audiology Hearing Screen and/or Diagnostic Evaluation Results

Child's Last Name First Name Middle Name Gender (Twin: A or B) Date of Birth

Birth Mother's Last Name First Name Maiden Name **State Lab TDH#**

Address City State/Zip Phone

Primary Care Provider Full Name Phone Foster Parent Name if Applicable

Birth Hospital Name: _____ City/State: _____

Date of Evaluation: ____/____/_____

Type of Evaluation: ☐ABR/AABR ☐OAE ☐Tymp/Reflex ☐ASSR ☐Behavioral

Mark: **Initial Screen** ☐ **Follow-Up Screen** ☐ **Diagnostic** ☐ (provide Diagnostic results at bottom of page)

Results: R: ☐Pass ☐Refer **L:** ☐Pass ☐Refer

Only mark one below:

☐ Results are **INCONCLUSIVE**. Please do not mark hearing loss if results are INCONCLUSIVE

☐ Probable Acute Fluctuating Conductive HL- No TDH Referrals needed at this time
Re-Evaluate on: ____/____/_____

NOTE:

- If hearing loss is marked below, **referrals for TEIS, CSS and Family Support WILL BE MADE.**

☐ **Diagnostic Results:** Normal Limits (0-15dB) ☐**R** ☐**L or** Hearing Loss ☐**R** ☐**L** (if HL provide degree and type)

If Hearing Loss, Degree (please mark):

Slight	(16-25dB)	☐R ☐L
Mild	(26-40dB)	☐R ☐L
Moderate	(41-55dB)	☐R ☐L
Moderately Severe	(56-70dB)	☐R ☐L
Severe	(71-90dB)	☐R ☐L
Profound	(91+dB)	☐R ☐L

If Hearing Loss, Type (please mark):

Unspecified HL	☐R ☐L
Chronic Fluctuating Conductive HL	☐R ☐L
Permanent Conductive HL	☐R ☐L
Mixed HL	☐R ☐L
Sensorineural HL (including Fluctuating)	☐R ☐L
Auditory Neuropathy/Dyssynchrony	☐R ☐L

Comments/Follow-Up: _____

Facility/Provider Name: _____ City:_____Phone_____

Risk Factors: (see below, check all that apply)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

1. NICU > 5 days
2. Syndrome associated with progressive or late onset HL
3. Family history of permanent childhood hearing loss
4. Craniofacial anomalies including those that involve the pinna, ear canal, ear tags, ear pits or temporal bone anomalies
5. In-utero infections such as CMV, Herpes, Rubella, Syphilis, & Toxoplasmosis
6. ECMO

A. Chemotherapy
B. Assisted ventilation
C. Ototoxic medications or loop diuretics
D. Hyperbilirubinemia requiring exchange transfusion
E. Physical findings such as white forelock associated with syndromes known to include SNHL or permanent conductive HL
F. Postnatal culture-positive infections associated with SNHL, including confirmed bacterial and viral (especially Herpes and Varicella), meningitis

Please COMPLETELY FILL OUT THIS FORM and fax to the Newborn Screening Program at 615-532-8555

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Unsedated/Sleep Deprived ABR Instruction

An Auditory Brainstem Response (ABR) test assesses hearing abilities to the level of the brainstem. This is done by measuring the brain's response to specific sound(s) presented to the ear. Total time for the procedure may be up to an hour and a half. The test is painless, but requires that the patient be sleeping and still. This is typically possible in infants less than six months old and children old enough to take a nap. Children older than 6months, or those who cannot sleep for the procedure in office, will have to be sedated.

In order to ensure the best results, and avoid sedation we ask that you:

1. **Skip the usual feeding prior to test**
2. **Skip the usual nap/sleep time prior to test**
3. **Do not put lotion on your child's head prior to test.**

When you arrive for the test, we will bring you to our test room where you may feed and rock your child to sleep. The lack of lotion ensures that our electrodes will stick to the skin and provide a better reading for our equipment. If you have any questions, you may feel free to contact our office at 865-521-6005

Patient Name:_____ DOB:_____

Scheduled ABR Date & Time:_____

Cancelling, no-showing, or rescheduling the unsedated ABR may result in having to sedate your child due to the small age window for unsedated testing.

I have read and understand what is required for my child's unsedated ABR

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Witness Signature **Date**

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SEDATED ABR/BAER PHYSICIAN ORDER

SEDATION SUITE_____OR_____

Date:_____

Patient Name: _____ **DOB:** _____

Parent's Name(s):_____

Address: _____

_____

Primary Phone: _____ **Secondary Phone:** _____

Insurance Carrier:_____

Diagnosis: _____

Physician (Please Print):_____

Physician Signature: _____

Discharge per Anesthesia protocol for Operating Room

Comments:_____

Appointment Date: _____ **@** _____**a.m./p.m.**

Please schedule and contact family
If there are any questions, regarding this order, please call 521-6005

Pre-Cert Codes

92585
92567
92587

Precert Required?_____

AUDIOLOGY fax to: Radiology/Sedation 541-8287 • **NURSING fax to:** Admitting 541-8289

This paper is ready to be filed_____

Office use only:
____Fax Radiology/call 541-8398 ____Inform Parents ____Black Book ____Call OR (541-8128)
____Schedule H&P ____Computer
____Schedule ear check with Andy (2-5 days before SS ABR)

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865-521-6005 / 865-521-6088 (FAX)

SEDATED ABR INFORMED CONSENT

Patient Name: _____ DOB: _____

Date of Evaluation: _____

1) I hereby request and authorize Dr. Little's, Dr. Belmont's, and Dr. Ray's Audiology team to assess the conditions that appear below:
Hearing loss

2) The following procedure(s) to be performed has been explained to me and I understand the nature of the procedure: **Auditory Brainstem Response (ABR)Testing under sedation and/or anesthesia at East Tennessee Children's Hospital**

3) Risks for this procedure include, but are not limited to the following:
Inability to complete study due to increased patient artifact and/or electrical interference with equipment; Inability to complete test due to technical or equipment malfunction; Inability to adequately sedate patient; Apnea (stoppage of breathing); Bradycardia (slowing of heart rate); Hypoxic Injury (too little oxygen to brain/body); Death

4) I understand that results are uncertain and no warranty or guarantee has been made to me.

5) I also understand that I will be responsible for any payment amount which insurance does not cover. It is my responsibility to ensure that insurance information is current and effective on dates of service.

CANCELLATION POLICY: A 5 DAY CANCELLATION NOTICE IS REQUIRED. YOU WILL BE PERMITTED TO RESCHEDULE THIS APPOINTMENT ONE TIME.

WE REQUIRE 24 HOURS NOTICE IF YOUR CHILD IS SICK. A DOCTOR'S EXCUSE WILL BE REQUIRED IN ORDER TO RESCHEDULE APPOINTMENT.

DISCHARGE OF PATIENT MAY RESULT FROM LACK OF COMPLIANCE.

I certify that I have read and fully understand this form, and that all of my questions have been answered in a satisfactory manner.

Patient (or Parent / Guardian) signature: _____
Printed name / Relationship: _____
Date: _____

Witness: _____
Date: _____

ABR Summary

Children's Ear, Nose and Throat Specialists, PLLC

_____Kristie Johnston, Au.D., CCC-A
_____Holly North, M.A., CCC-A
_____Emily Morgan, Au.D.
_____Kristi Walden, Au.D., CCC-A
_____Samantha Wallenstein, Au.D., CCC-A

Patient Name:_____
Chart Number:_____
DOB:_____
DOE:_____

	LEFT EAR	RIGHT EAR
Tympanometry		
OAEs (2-6kHz)		
CLICK (2-4kHz) 10dB CF	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**
Absolute Latencies: *Interpeak Latencies:* ILV V: _____ <.5	I:_____ <1.90 III:_____ <4.35 V:_____ <6.25 I-III:_____ <2.55 III-V:_____ <2.35 I-V:_____ <4.60	I:_____ <1.90 III:_____ <4.35 V:_____ <6.25 I-III:_____ <2.55 III-V:_____ <2.35 I-V:_____ <4.60
RATE STUDY		
POLARITY STUDY		
500Hz 20dB CF	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**
1000Hz 15dB CF	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**
2000Hz 10dB CF	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**
4000Hz 5dB CF	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**
Bone Conduction 30dB CF (CLICK 2-4KhZ)	_____dBnHL **corrected:_____dBeHL**	_____dBnHL **corrected:_____dBeHL**

ABN= Abnormal; WNL= Within Normal Limits; CF= Correction Factor

Pediatric Otolaryngology - Head and Neck Surgery, PLLC

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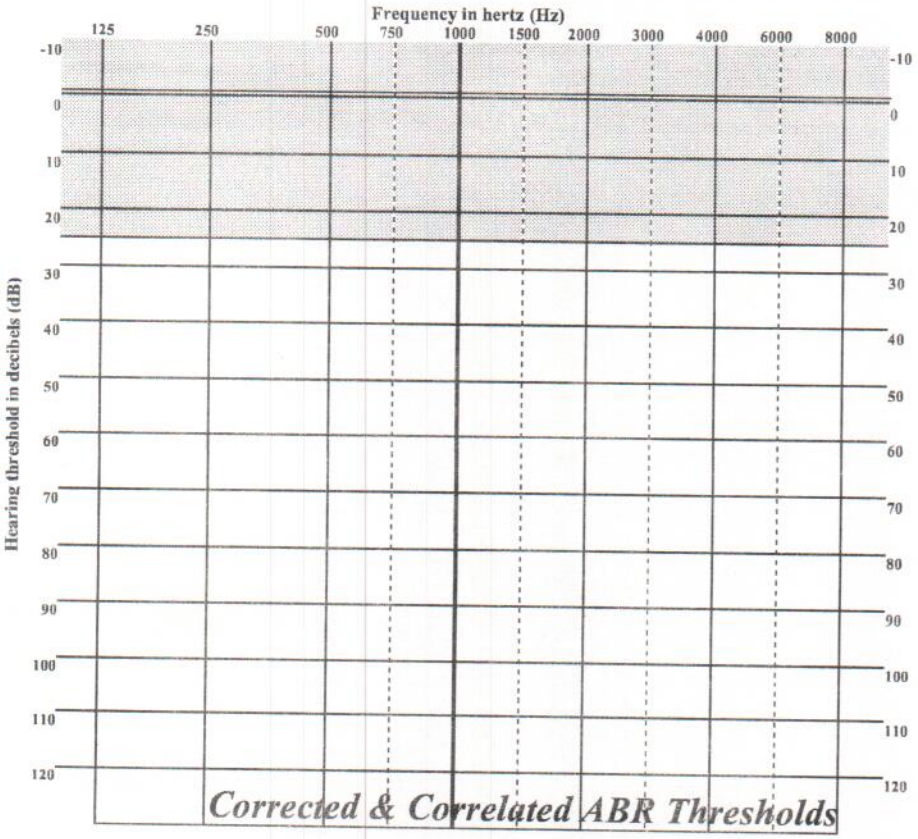
AUDITORY BRAINSTEM RESPONSE

Name_____ **Date of Evaluation**_____

Date of Birth_____ **Age**_____ **Sex**_____ **Chart Number**_____



AUDIOGRAM KEY

	RIGHT	LEFT
AC UNMASKED -	O	X
AC MASKED -	Δ	□
BC UNMASKED-	<	>
BC MASKED-	[	]
NO RESPONSE	↙	↘
THRESHOLD-	THR or □	

BIOLOGIC NAVIGATOR PRO
Insert Earphones

- € Sedated Operating Room
- € Sedated Sedation Suite
- € Unsedated

MORPHOLOGY/REPEATIBILITY

- € GOOD
- € FAIR
- € POOR

POLARITY STUDY
3KhZ Click at 80dB

RIGHT ☐WNL ☐ABNORMAL
LEFT ☐WNL ☐ABNORMAL

RATE STUDY
3KhZ Click at 80dB
27.7 vs. 57.7

RIGHT ☐ WNL ☐ABNORMAL
LEFT ☐ WNL ☐ABNORMAL

TYMPANOGRAM

				Pressure	Volume
RE	A	B	C		
LE	A	B	C		

3kHz Click WNL:
☐ RIGHT
☐ LEFT

Distortion Product Otoacoustic Emissions
(DPOAEs)

RT EAR: ☐PASS ☐REFER ☐History WNL

LT EAR: ☐PASS ☐REFER ☐History WNL

TESTED BY: ____K. Johnston, Au.D.,CCC-A_____H. North, M.A.,CCC-A____K. Walden, Au.D.____S. Wallenstein, Audiology Extern

Hearing WNL ***(to the level of the brainstem)*****:** ☐**Right** ☐**Left** ☐ Discussed results with parents

Hearing loss right: _____ Type: ☐CHL ☐SNHL ☐mixed

Hearing loss left: _____ Type:☐CHL ☐SNHL ☐mixed

☐Recommend Sedated ABR ☐Re-evaluate behaviorally for ear specific in _____ ☐Re-evaluate behaviorally in soundfield in_____

Comments: _____

_____

HEARING AID
LOG SHEET

REPAIR LOG

Date	Problem	Sent for Repair	Returned	Parent Contacted

CONTACT LOG

Date:	Type

HA forms

TRACKING FORM FOR HEARING AID PATIENTS
Children's Hearing Center of East Tennessee

Name:_____ **DOB:** _____ **Date of Evaluation:**_____

Audiologist: ___**Kristie Johnston, Au.D., CCC-A** ____**Holly North, M.A., CCC-A**
____**Emily Morgan, Au.D.** ____**Kristi Walden, Au.D., CCC-A**
_____ **Samantha Wallenstein, Au.D., CCC-A**

Reason child was seen

- ☐ Hearing Aid Evaluation
- ☐ Initial two week follow-up
- ☐ Hearing Aid Orientation
- ☐ Routine Hearing Aid Check

Tympanograms: Right _____ Left _____ **Tubes:** Right ☐ Left ☐

Date of Last Audio: _____ **Last Earmold Impression:** _____

Parent Report_____
_____
_____

HEARING AID INFORMATION:

	Make	Model	Serial Number	Warranty Exp.
Right:				
Left:				

Settings:

- ☐ *Adaption Level:* 1 2 3 4
- ☐ *Volume Control:* ON OFF
- ☐ *Program Button*ON OFF

P1	P2	P3	P4

Listening Check:

- ☐ Good Working Order ☐ Concern:_____

Earmolds:

- ☐ Good fit @ ___Right ___Left
- ☐ Concern: _____

Verifit:

- ☐ REMS ☐ SREMs
- ☐ Measured RECDs ☐ Avg RECDs ☐ RECDs from:_____
- ☐ Match to Targets: __Good __Fair __Poor

Software Changes:_____
_____

Hearing Aid Repairs:

- ☐ Re-Tubed ☐Mic Covers/Filters ☐New Tone Hook
- ☐ Earmold Modification ☐Cleaning ☐ ***Sent in for Repair*** ___**R** ___**L**

Return for Follow-Up: _____

Comments:_____
_____

Children's Hearing Center of East Tennessee
Verifit Measurements

Name:_____

Date:_____

_____Kristie Johnston, Au.D., CCC-A
_____Holly North, M.A., CCC-A
_____Emily Morgan, Au.D.
_____Kristi Walden, Au.D. CCC-A
_____Samantha Wallenstein, Au.D, CCC-A

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MEDICAL WAIVER

I have been advised by the professional on this document that the FDA has determined that my best interest would be served if I have a medical evaluation by a licensed physician before purchasing a hearing aid. I do not wish to obtain a medical evaluation before purchasing a hearing aid(s).

Patient_____ Date_____

Patient Signature_____

Audiologist_____ Date_____

Audiologist Signature_____

Audiologist Extern (if applicable)_____

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR THE COST OF SERVICES

I agree to pay the full cost of the hearing aids. I have verified that my health insurance does not cover the cost of hearing aids. I understand that Children's Ear, Nose and Throat Specialists will not file the hearing aid charges to my insurance company.

_____ _____

Parent/Guardian Date

_____ _____

Witness Date

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HEARING AID PRESCRIPTION

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

	RIGHT EAR	LEFT EAR
Manufacturer:	_____	_____
Model:	_____	_____
Color:	_____	_____
Misc:	_____	_____

Trial period: 60 days from time of issuance. The hearing aid(s) maybe returned within this trial period for a refund minus $100.00 restocking fee per hearing aid.

Quote: $_____ for one hearing aid
$_____ for two hearing aids

***Payment requirement: 50% at time of order, balance at fitting**
***Custom earmold are nonrefundable. Custom earmold price, if applicable $_____**
***This quote is valid for 30 days from the date listed.**
LOSS AND DAMAGED BEYOND REPAIR-PROFESSIONAL FEE OF $150 PER HEARING AID, NOT BILLABLE TO INSURANCE COMPANY

Services Provided at No Additional Charge:

1. Hearing aid Evaluation
2. Hearing aid Fitting
3. Pediatric Care Kit, which includes:
    a. Battery tester
    b. Dehumidifier
    c. Listening tube
    d. Air blower
    e. Retention Clip, when applicable
4. Up to ten follow-up visits a year during the warranty period (typically 3 years), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

I agree to pay the full cost of the hearing aids. I have been informed that my health care benefits insurer may cover a portion of the hearing aid costs. If Children's Ear, Nose, and Throat Specialists receives a payment from the insurance company, a refund check will be mailed to me.
I also understand that no contractual insurance adjustment or discount will be applied to the cost.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

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HEARING AID ISSUANCE FORM

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

	RIGHT EAR	LEFT EAR
Manufacturer:	_____	_____
Model:	_____	_____
Serial #:	_____	_____
Battery Size:	_____	_____
Color:	_____	_____
Misc:	_____	_____

Factory Warranty Expiration Date: _____

Trial period: **60 days from time of issuance**. The hearing aid(s) maybe returned within this trial period for a refund minus **$100.00** restocking fee per hearing aid.

LOSS AND DAMAGED BEYOND REPAIR –PROFESSIONAL FEE OF $150 PER HEARING AID, NOT BILLABLE TO INSURANCE COMPANY

Services Available During Warranty Period at No Additional Charge:

1. Initial hearing aid evaluation and fitting
2. Hearing aid programming/adjustments
3. Pediatric Care Kit, which includes:
    a. Battery tester
    b. Dehumidifier
    c. Listening tube
    d. Air blower
    e. Retention Clip, when applicable
4. Up to ten follow-up visits a year during the warranty period (typically 3 years), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

WARNING: Hearing aid batteries can be dangerous if swallowed or improperly used. Please take care to keep them out of reach of small children.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

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ADULT
HEARING AID ISSUANCE FORM

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

	RIGHT EAR	LEFT EAR
Manufacturer:		
Model:		
Serial #:		
Battery Size:		
Color:		
Misc:		

Factory Warranty Expiration Date: _____

Trial period: **60 days from time of issuance**. The hearing aid(s) maybe returned within this trial period for a refund minus **$100.00** restocking fee per hearing aid.

LOSS AND DAMAGED BEYOND REPAIR –PROFESSIONAL FEE OF $150 PER HEARING AID, NOT BILLABLE TO INSURANCE COMPANY

Services Available During Warranty Period at No Additional Charge:

1. Initial hearing aid evaluation and fitting
2. Hearing aid programming/adjustments
3. Dehumidifier/Dry Aid Kit included in purchase of Hearing Aids
4. Up to ten follow-up visits a year during the warranty period (typically 3 years), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

WARNING: Hearing aid batteries can be dangerous if swallowed or improperly used. Please take care to keep them out of reach of small children.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

Hearing Aids paid in full _____

Children's Ear, Nose & Throat Specialists, PLLC

* **John P. Little, M.D.**
Board Certified
Fellowship Trained

chael J. Belmont, M.D.
Board Certified
Fellowship Trained

R. Mark Ray, M.D.
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Kristie Johnston, Au.D.
CCC-A
Holly North, M.A.
CCC-A
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amantha Wallenstein, M.S.
Audiology Extern

Janet L. Harris
Office Manager

* Implant Surgeon,
Pediatric Cochlear
Implant Program
At Children's Hospital

Children's Hospital
edical Office Building
2100 Clinch Avenue
Suite 410
Knoxville, TN 37916

865-521-6005
fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

ADULT
HEARING AID PRESCRIPTION

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

	RIGHT EAR	LEFT EAR
Manufacturer:	_____	_____
Model:	_____	_____
Color:	_____	_____
Misc:	_____	_____

Trial period: 60 days from time of issuance. The hearing aid(s) maybe returned within this trial period for a refund minus $100.00 restocking fee per hearing aid.

Quote: $_____ for one hearing aid
$_____ for two hearing aids

***Payment requirement: 50% at time of order, balance due at fitting of hearing aid**
***Custom earmold are nonrefundable. Custom earmold price, if applicable $_____**
***This quote is valid for 30 days from the date listed.**
LOSS AND DAMAGED BEYOND REPAIR-PROFESSIONAL FEE OF $150 PER HEARING AID, NOT BILLABLE TO INSURANCE COMPANY

Services Provided at No Additional Charge:

1. Hearing aid Evaluation
2. Hearing aid Fitting
3. Dehumidifier/Dry Aid Kit included in purchase of Hearing Aids
4. Up to ten follow-up visits a year during the warranty period (typically 3 years), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

I agree to pay the full cost of the hearing aids. I have been informed that my health care benefits insurer may cover a portion of the hearing aid costs. If Children's Ear, Nose, and Throat Specialists receives a payment from the insurance company, a refund check will be mailed to me.
I also understand that no contractual insurance adjustment or discount will be applied to the cost.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

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fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

NAIDA LINK HEARING AID ISSUANCE FORM

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

Manufacturer: Phonak

Model: Naida Link

Serial #: _____

Battery Size: _____

Color: _____

Misc: _____

Hearing Aid Factory Warranty Expiration Date: _____

Ear Mold(s) Remake Expiration Date: _____

Trial period: **60 days from time of issuance**. The hearing aid maybe returned within this trial period for a refund minus **$100.00** restocking fee.

Loss and Damage beyond repair- Professional fee of **$150**, not billable to insurance company.

Services Available During Warranty Period at No Additional Charge:

1. Initial hearing aid evaluation and fitting
2. Hearing aid programming/adjustments
3. Pediatric Care Kit, which includes:
    a. Battery tester
    b. Dehumidifier
    c. Listening tube
    d. Air blower
    e. Retention Clip, when applicable
4. Up to ten follow-up visits during the warranty period (typically 1 year), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

WARNING: Hearing aid batteries can be dangerous if swallowed or improperly used. Please take care to keep them out of reach of small children.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

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NAIDA LINK HEARING AID PRESCRIPTION

Name: _____ **Date of Birth:** _____

Chart #: _____ **Today's Date:** _____

Diagnosis/ Hearing Loss: _____

	RIGHT EAR	LEFT EAR
Manufacturer:	_____	_____
Model:	_____	_____
Color:	_____	_____
Misc:	_____	_____

Trial period: 60 days from time of issuance. The hearing aid maybe returned within this trial period for a refund minus $100.00 restocking fee per hearing aid.

Quote: $1700 for one hearing aid

***Payment requirement: 50% at time of order, balance at fitting**
***$350 Professional fitting fee included**
***Custom earmold is nonrefundable. Custom earmold price, if applicable $90**
***Warranty is as follows: Hearing Aid 1 year; Earmold Remake 30 days**
***This quote is valid for 30 days from the date listed.**

Services Provided at No Additional Charge:

1. Hearing aid Evaluation
2. Hearing aid Fitting
3. Pediatric Care Kit, which includes:
    a. Battery tester
    b. Dehumidifier
    c. Listening tube
    d. Air blower
    e. Retention Clip, when applicable
4. Up to ten follow-up visits during the hearing aid warranty period (typically 1 year), including:
    a. Hearing aid adjustments and programming
    b. Hearing aid cleanings
    c. Hearing aid troubleshooting and repairs

I agree to pay the full cost of the hearing aid. I have been informed that my health care benefits insurer may cover a portion of the hearing aid costs. If Children's Ear, Nose, and Throat Specialists receives a payment from the insurance company, a refund check will be mailed to me.
I also understand that no contractual insurance adjustment or discount will be applied to the cost.

Guardian's Signature: _____ Date: _____

Audiologist: _____ Date: _____

Children's Hearing Center
of East Tennessee

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A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Medical Clearance for Hearing Aid(s)

Patient:

Date of Birth:

Chart:

I have evaluated the above patient and there is not a medical contraindication for him/her to receive hearing aid(s).

Comments:

_____ _____

Physician Date

Jones | Therapy Services

Referral for Speech-Language, Feeding, Occupational and/or Physical Therapy

Date:	Facility:	Physician Referring:

Patient Name:	DOB:
Diagnosis:	
Parent/Guardian Name:	Phone #:

Services Requested:

☐	Speech-Language Evaluation and Treatment	☐	Occupational Therapy Evaluation and Treatment
☐	Feeding Evaluation and Treatment	☐	Physical Therapy Evaluation and Treatment
☐	Augmentative Communication Device Evaluation		

Physician Comments/Concerns:

Physician Signature:

Check all that apply to patient:

☐	Articulation (speech sound errors)	☐	Non-Oral Communication (device needed)
☐	Cleft Lip/Palate	☐	Tracheotomy
☐	Language Delay	☐	Tube Fed
☐	Voice Quality	☐	Sensory Needs
☐	Limited Oral Expression	☐	Fine or Gross Motor Development Needs
☐	Other (Please describe):		

Please send any relevant patient information (including insurance information and preferred contact information for patient) needed for referral. Our office will take care of verifying insurance coverage and benefits and will contact the family to schedule appointments. A copy of the evaluation will be sent to your office upon completion and progress notes may be sent at the request of the referring provider.

Hearing and Speech Center (UTK Campus)
1600 Peyton Manning Pass
Knoxville, TN 37996-2500
Phone: 865-974-5451
FAX: 865-974-4639

NEW PATIENT REFERRAL FORM - *SPEECH-LANGUAGE*

Revised 11/2016

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Male/Female

Parent/Spouse/Guardian: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PURPOSE OF REFERRAL [ ] Evaluation (including a hearing evaluation, if indicated)
[ ] Treatment

PLEASE NOTE: This referral is effective for *one year* from the date a properly completed and signed form is received. Our center will send requests to update referrals annually on established patients.

AREAS OF CONCERN (check any that apply)

[ ] Speech [ ] Reading [ ] Traumatic Brain Injury [ ] Fluency [ ] Apraxia [ ] Autism
[ ] Language [ ] Voice [ ] Feeding/Swallowing [ ] Aphasia [ ] Cognition

ADDITIONAL PROCEDURES [ ] Stroboscopy (Voice) [ ] Swallowing Evaluation: Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

PERTINENT MEDICAL HISTORY with ASSOCIATED ICD-10 DIAGNOSIS CODE/S _____

_____

PROVIDER INFORMATION

Referring Physician: _____
Address: _____
Phone #: _____ Fax #: _____
Provider's NPI: _____
Primary Care Provider: _____
Phone #: _____ Fax #: _____
Provider's NPI: _____

- **Before we can schedule your patient and bill for insurance we must have the referring provider's NPI.**
- **Please also send *all* relevant medical notes or test results**

Is this patient currently receiving home healthcare services?

[ ] No [ ] Yes List Provider _____

INSURANCE INFORMATION

Primary Carrier: _____
Subscriber ID#: _____ Group #: _____
Secondary Carrier: _____
Subscriber ID#: _____ Group #: _____
Is a pre-cert or authorization number Required? Yes or No
Authorization/pre-cert #: _____ # of visits: _____
Dates visits are valid: _____

AND

- **Send a copy of the patient's insurance card/s (front and back)**

Referring Provider's Signature (Required): _____ **Date:** _____

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

Audiology Clinic (UTK Campus)
455 South Stadium Hall
Knoxville, TN 37996-0740
Phone: 865-974-5453
FAX: 865-974-1792

NEW PATIENT REFERRAL FORM - *AUDIOLOGY*

Revised 4/2017

PATIENT INFORMATION

Patient Name:_____ DOB:_____ Male/Female

Parent/Spouse/Guardian: _____

Address:_____ City:_____ State:___ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

CHIEF COMPLAINT and/or DIAGNOSIS (i.e. hearing loss, tinnitus, dizziness)

List all that apply including associated ICD-10 Code(s): _____

MEDICAL CLEARANCE: Is there any medical basis to contraindicate the use of hearing aids if the patient meets candidacy? Yes _____ No _____

PURPOSE OF REFERRAL: (*Check all appropriate*)

[ ] Adult Hearing Evaluation
[ ] Cerumen Management
[ ] Pediatric Hearing Evaluation (including a speech-language evaluation, if indicated) [ ] Amplification Evaluation
[ ] Auditory Processing Evaluation - Age 7 & Older (including a speech-language evaluation, if indicated)
[ ] Dizziness Clinic Evaluation
[ ] Tinnitus Evaluation (including a Hearing Evaluation, if indicated)
[ ] Unilateral Hearing Loss Evaluation (including spatial hearing evaluation)
[ ] Neurological Auditory Brainstem Response Evaluation (ABR)
[ ] Threshold Auditory Brainstem Response Evaluation (ABR) and/or Pediatric Hearing Evaluation
[ ] Electrocochleography (ECochG)
[ ] Cochlear Implant Programming
[ ] Cochlear Implant Assessment (Pre/Post) including Dizziness Clinic Evaluation Date of CI surgery: _____
[ ] Aural Oral Evaluation/Speech-Language Evaluation [ ] Aural Re/Habilitation (Speech) Therapy

PLEASE NOTE:
This referral is effective for **one year** from the date received.
Our Center will send requests to update referrals on established patients.

PROVIDER INFORMATION

Referring Physician: _____
Address: _____
Phone #:_____ Fax #: _____
Provider's NPI: _____
Primary Care Provider: _____
Phone #:_____ Fax #: _____
Provider's NPI: _____

- **Before we can schedule your patient and bill for insurance we must have the referring provider's NPI.**
- **Please also send *all* relevant medical notes or test results**

Is this patient currently receiving home healthcare services?

[ ] No [ ] Yes List provider _____

INSURANCE INFORMATION

Insurance Carrier:_____
Medicare? Yes/No Supplemental? Yes/No TennCare? Yes/No
Subscriber ID#:_____ Group #: _____
Is a **pre-cert or authorization number Required**? Yes or No
Authorization/pre-cert #:_____ # of visits: _____

AND

- **Send a copy of the patient's insurance card (front and back)**

Referring Provider's Signature (required for patients 21 years and under):_____ **Date:** _____

Initial Referral Form

Phone: 865-579-3099; Fax: 865-579-5033

Rev. 3/19/14

OFFICE USE ONLY
In TEIDS: _____
Cc: _____
Letters sent: _____
County: _____
SC: _____
45 days: _____
ID#: _____

Date: _____

Child's Name: _____

DOB: _____-_____-_____ **Gender:** male female **SSN:** _____-_____-_____

Race: American Indian Asian Black Hispanic White **Language other than English:** _____

Child's Address: _____

City: _____ Zip: _____ County: _____

Referent Name: _____ Agency Name: _____

Phone: _____ FAX: _____

Reason for Referral: _____

How did you hear about TEIS? _____

Pediatrician: _____ Group Name: _____

Phone: _____ FAX: _____

Insurance: _____

Guardian: Biological Foster Kinship

Mother: _____ Phone: _____

Father: _____ Phone: _____

Guardian: _____ Phone: _____

NOTES:

TRACKING FORM FOR COCHLEAR IMPLANT PATIENTS—BEHAVIORAL EVALUATION ONLY
Children's Hearing Center of East Tennessee

Name_____ **DOB:**_____ **Date of Evaluation**_____

Audiologist:

_____Kristie Johnston, Au.D., CCC-A
_____Emily Morgan, Au.D.
_____Holly North, M.A., CCC-A
_____Kristi Walden, Au.D., CCC-A
_____Samantha Wallenstein, Au.D., CCC-A

Reason child was seen

- ☐ Concern of patient/Parent/etc.
- ☐ New or replacement device fitting
- ☐ Routine visit

Processor/Serial Number (s) Upon Arrival:

R	L	Settings	R	L	Settings

Start Time: _____

End Time: _____

Parent Report_____

_____

Therapy_____ **Dr. Little**_____

STATUS UPON ARRIVAL:

Magnet strength: _____

- ☐ Discussed observation of skin ...elling, irritation, etc.

Ear and head check:

- ☐ No Concern
- ☐ Concern:_____

Equipment check:

- ☐ Good working condition
- ☐ Request RMA for _____
- ☐ Request insurance reimburse

Impedances:

- ☐ All values were acceptable
- ☐ The following electrodes dis...
- ☐ The following electrodes were deactivated _____

Evaluation:

- ☐ **Audio acceptable** Right_____ Left_____
- ☐ **Audio indicates need for follow-up mapping** Right_____ Left_____
- ☐ **Audio acceptable but patient indicates desire for programming changes** Right _____ Left_____
  Comments:_____

Tympanograms: Right _____ Left _____

Return for follow-up _____

Comments_____

_____

_____

TRACKING FORM FOR COCHLEAR IMPLANT PATIENTS—MAPPING APPOINTMENT

Children's Hearing Center of East Tennessee

Name_____ **DOB:**_____ **Date of Evaluation**_____

Audiologist:

_____Kristie Johnston, Au.D., CCC-A
_____Emily Morgan, Au.D.
_____Holly North, M.A., CCC-A
_____Kristi Walden, Au.D., CCC-A
_____Samantha Wallenstein, Au.D., CCC-A

Reason child was seen

- ☐ Initial Stimulation
- ☐ Concern of patient/Parent/etc.
- ☐ New or replacement device fitting
- ☐ Routine visit

Processor(s) status upon arrival:

Right: _____ Settings P_____ Map#_____ Serial #_____

Left: _____ Settings P_____ Map#_____ Serial #_____

Parent Report_____

Therapy_____ **Last Seen by Dr. Little**_____

STATUS UPON ARRIVAL:

Magnet strength: _____

- ☐ Discussed observation of skin beneath the site of the coil placement for redness, swelling, irritation, etc.

Ear and head check:

- ☐ No Concern
- ☐ Concern:_____

Equipment check:

- ☐ Good working condition
- ☐ Request RMA for _____
- ☐ Request insurance reimbursement for _____

PROGRAMMING

Impedances:

- ☐ All values were acceptable
- ☐ The following electrodes displayed abnormal values _____
- ☐ The following electrodes were deactivated _____

NRT: _____

Tympanograms: Right _____ Left _____

STATUS AT DEPARTURE—*MAP NUMBERS & SETTINGS*

Primary Processor/Serial Number (s):

	R	L	Settings
P1			
P2			
P3			
P4			
P5			

	R	L	Settings
P1			
P2			
P3			
P4			
P5			

Backup Processor/Serial Number (s): ☐ **DID NOT BRING**

	R	L	Settings
P1			
P2			
P3			
P4			
P5			

	R	L	Settings
P1			
P2			
P3			
P4			
P5			

Return for follow-up _____

Comments_____

Start Time: _____ End Time: _____

TRACKING FORMS FOR BAHA PATIENTS
Children's Hearing Center for East Tennessee

Name: _____ **DOB:**_____ **Date of Evaluation:**_____

Audiologist: _____Kristie Johnston, Au.D., CCC-A
_____Emily Morgan, Au.D.
_____Holly North, M.A., CCC-A
_____ Kristi Walden, Au.D., CCC-A
_____ Samantha Wallenstein, Au.D., CCC-A

Last seen by physician:_____

REASON CHILD WAS SEEN:

- ☐ Initial Fitting
- ☐ Routine visit
- ☐ Concern of patient/parent/teach/audiologist/therapist
- ☐ New or replacement device fitting
- ☐ Child not seen, programs placed on replacement device only

Start Time: _____ End Time: _____

PARENT REPORT:

_____

_____

STATUS UPON ARRIVAL

Device:

- ☐ Softband
- ☐ Implant

Processor(s): **Right:** _____ Program:_____ S/#:_____ Color:_____
Left: _____ Program:_____ S/ #:_____ Color:_____

Ear and Head Check:

- ☐ No Concern
- ☐ Concern:_____

Equipment Check:

- ☐ Good working condition
- ☐ Problem found with:_____
- ☐ Request RMA for:_____
  - ○ _____
- ☐ Request Insurance Reimbursement:_____

_____

Evaluation:

- ☐ Audio acceptable_____
- ☐ Audio indicates need for follow up programming _____

STATUS AT DEPARTURE

Primary Processor(s):

Right S/#:_____
Color:_____
P1:_____
P2:_____
P3:_____

Left S/#:_____
Color:_____
P1:_____
P2:_____
P3:_____

Backup Processor(s):

Right S/#:_____
Color:_____
P1:_____
P2:_____
P3:_____

Left S/#:_____
Color:_____
P1:_____
P2:_____
P3:_____

RETURN FOR FOLLOW-UP:_____

COMMENTS:

_____

_____

_____

Pediatric Otolaryngology - Head and Neck Surgery, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

Children's Hospital Medical Office Building
2100 Clinch Avenue, Suite 410 / Knoxville, TN 37916
(865) 521-6005 • (865) 521-6088 FAX

Audiology Progress Note

Name_____ Date of Evaluation_____

Date of Birth_____ Age_____ Sex_____ Chart Number_____

History: _____

Audiological findings: _____

Plan: _____

TESTED BY:____K. Johnston, Au.D. ____H. North, M.A.____K. Walden, Au.D .____S. Wallenstein, Au.D.____Audiology Extern

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fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

NEWBORN HEARING EVALUATION

Name: _____ **DOB:** _____ **Date:** _____

HISTORY:

Weeks Gestation at Birth: _____

NICU Stay/Risk Factors: _____

Normal Preganancy: YES NO
Complications:

Family History of Hearing Loss: YES NO
Comments:

Previous Newborn Hearing Screening: YES NO
IF YES: At: _____
Obtained by: DPOAEs ALGO ABR
Abnormal responses at the: Right Ear Left Ear

TODAY'S EVALUATION:
Distortion Product Otoacoustic Emissions (DPOAEs): Right: Pass Refer
Left: Pass Refer

Auditory Brainstem Response (ABR):
Right: _____
Left: _____

RECOMMENDATIONS:
_____Refer back to pediatrician for medical management
_____Consider Pediatric Otolaryngology referral
_____Reevaluate hearing following medical management in _____
_____Reevaluate hearing in soundfield in _____

Comments:
_____
_____

Thank you for this referral! It was a pleasure to be a part of the hearing healthcare of your patients.

_____ Kristie Johnston, Au.D., CCC-A _____Emily Morgan, Au.D. _____Holly North, M.A., CCC-A
_____Kristi Walden Au.D., CCC-A _____Samantha Wallenstein, Au.D., CCC-A

Results cc-ed to TNDOH Newborn Hearing Screening

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fax 865-521-6088

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HEARING EVALUATION

Name: _____ **DOB:** _____ **Date:** _____

History:

Family History of Hearing Loss: Yes No

Otoscopy: Right: ____ unremarkable Comment: _____
Left: ____ unremarkable Comment: _____

Tympanometry: Right: Type _____ Pressure _____ Volume _____
Left: Type _____ Pressure _____ Volume _____

Distortion Product Otoacoustic Emissions (DPOAEs): Right: Pass Refer
Comments: Left: Pass Refer

Speech Reception/Awareness Thresholds: Right _____dB Left _____dB Sound field _____dB

Word Recognition Scores: Right _____% at _____dB Left _____% at _____dB

Behavioral Evaluation: _____Visual Reinforcement Audiometry (VRA)
_____Conditioned Play Audiometry (CPA)

Results: Hearing WNL: _____Right _____Left _____Sound field (for at least one ear)
Hearing Loss Sound field: _____
Hearing Loss Right: _____
Hearing Loss Left: _____

Recommendations:
_____Refer back to pediatrician for medical management
_____Consider Pediatric Otolaryngology evaluation
_____Reevaluate hearing following medical management in _____
_____Reevaluate hearing in _____
_____Reevaluate hearing at 3 years of age (when ear specific thresholds can be obtained)
_____No further audiological follow up is necessary

Comments:

_____

_____

Thank you for this referral! It was a pleasure to be a part of the hearing healthcare of your patients.

____K. Johnston, Au.D. ____E. Morgan,Au.D. _____H. North, M.A. ____K. Walden, Au.D. _____ S. Wallenstein, Au.D.

Children's Ear, Nose and Throat Specialists , PLLC
Drs. Little, Belmont and Ray
Kristie Johnston, Au.D. ,CCC-A//Emily Morgan, Au.D.//Holly North, M.A., CCC-A
K. Walden, Au.D.,CCC-A//S. Wallenstein,Au.D.,CCC-A
865-521-6005//(f)865-521-6088

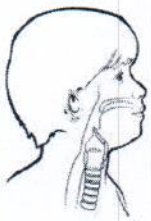
PATIENT NAME:_____ CHART#:_____

RIGHT

Date	Tymp	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz

LEFT

Date	Tymp	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz



Children's Ear, Nose & Throat Specialists

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

East Office
Children's Hospital Medical Office Building
2100 Clinch Avenue, Suite 410 / Knoxville, TN 37916
(865) 521-6088 FAX

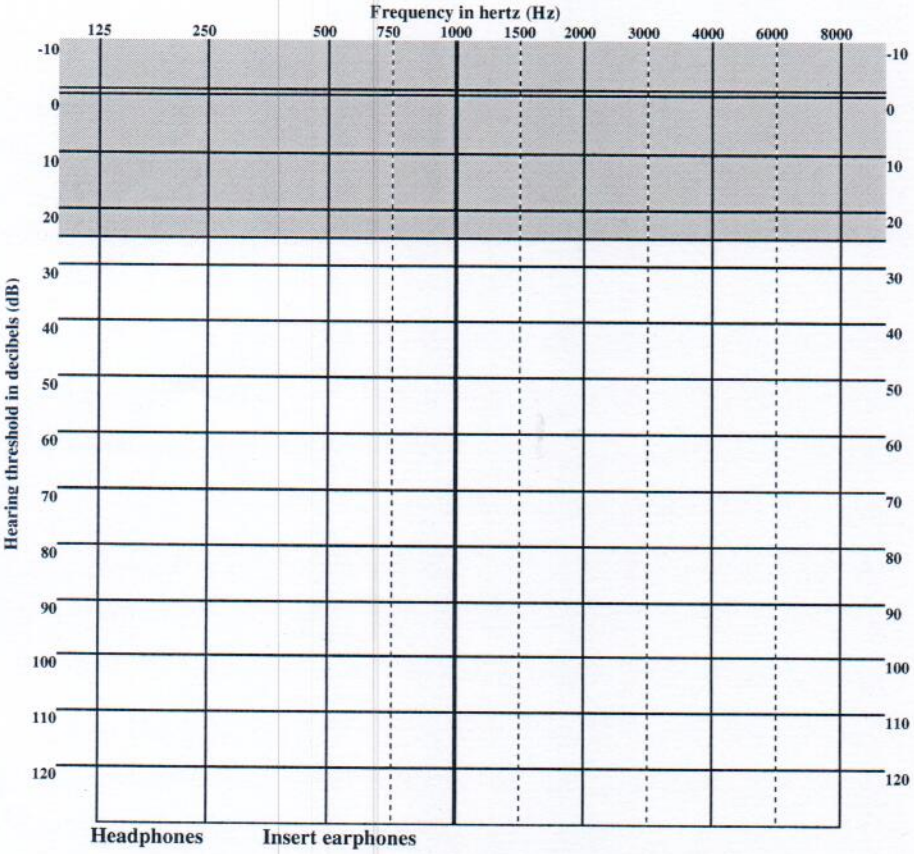
West Office
9546 S. Northshore Drive
Knoxville, TN 37922
(865) 415-3430

PHONE: (865) 521-6005

AUDIOLOGICAL EVALUATION

Name_____ **Date of Evaluation**_____

Date of Birth_____ **Age**_____ **Sex**_____ **Chart Number**_____



AUDIOGRAM KEY

	RIGHT	LEFT
AC UNMASKED -	O	X
AC MASKED -	Δ	□
BC UNMASKED-	<	>
BC MASKED-	[	]
NO RESPONSE	↙	↘
SOUND FIELD - THRESHOLD-	* THR or θ	

AUDIOMETER
CALIBRATED TO ANSI STANDARD
GSI 61
☐ East Office ☐ West Office
☐ Booth A ☐ Booth B

RELIABILITY	METHOD
☐GOOD	☐VRA
☐FAIR	☐CPA
☐POOR	☐BOA

- ☐ COULD NOT CONDITION
- ☐ SCARED OF VRA
- ☐ DID NOT TEST <15dB
- ☐ FATIGUED
- ☐ COULD NOT TEST MASKED BC

PURE TONE AVERAGE
(500, 1000 & 2000Hz)
Air Rt____dB Lt____dB

TYMPANOGRAM

				Pressure	Volume
RE	A	B	C		
LE	A	B	C		

SPEECH (live voice)
Reception
Awareness
RT EAR_____dB LT EAR_____dB

THRESHOLD
Sound Field_____dB

WORD RECOGNITION SCORES (live voice)

		MCL	UCL
RT EAR _____	% AT _____dB	____ dB	____dB
LT EAR _____	% AT _____dB	____ dB	____dB

Stimuli_____

TESTED BY: _____K. Johnston, Au.D. _____E. Morgan, Au.D. _____H. North, M.A. _____K. Walden, Au.D. _____S. Wallenstein, Au.D.

Hearing WNL: ☐right ☐left ☐soundfield *(for at least one ear)* Hearing loss soundfield:_____

Hearing loss right: _____ Type: ☐CHL ☐SNHL ☐mixed

Hearing loss left: _____ Type: ☐CHL ☐SNHL ☐mixed

DPOAEs 2-6Khz: RIGHT: ☐Pass ☐Refer LEFT: ☐Pass ☐Refer ☐History normal DPOAEs R/L ☐Recommend Sedated ABR

☐Discussed results with parents ☐Counseled parents on practicing CPA ☐History ABR WNL R/L ☐Stable Hearing R/L ☐Dev. Delay

Reevaluate: ☐following medical management ☐at 3years for ear specific ☐DPOAEs when ears clear ☐to complete HT ☐as needed

Comments: _____