DEPARTMENT OF HEALTH

Audiology Amplification Report

EARLY HEARING DETECTION AND INTERVENTION

Audiologist's name:_____

Audiologist's fax number: _____

To improve the access and quality of systems affecting children with hearing loss, please help us identify the utilization of services for the child listed below.
Please return this completed form to confidential fax number: **651-201-3655**.

Child's name:_____

Child's date of birth: _____

1. Amplification information (select one)

☐ Fitting has occurred. Fit date: _____

Amplification loaner used?

- ◯ Yes – State of MN Pediatric Hearing Device Loaner Program.
- ◯ Yes – Other.
- ◯ No.

☐ Fitting in process. Expected fit date (if known): _____

☐ Waiting to fit. Reason: _____

☐ Family chose not to pursue amplification at this time (declined).

☐ Amplification not indicated or recommended. Reason:_____

☐ Child has not returned to this clinic for fitting (lost to follow up).

☐ Child is being seen by another provider or clinic. Provider (if known): _____

☐ Other. Reason (if known):_____

2. Type of technology (select one)

Left: ◯ hearing aid ◯ bone conduction ◯ cochlear implant ◯ remote microphone/FM ◯ none

Right: ◯ hearing aid ◯ bone conduction ◯ cochlear implant ◯ remote microphone/FM ◯ none

3. Family's primary language (select one)

☐ English ☐ Somali ☐ Hmong

☐ ASL ☐ Spanish ☐ Other. Language (if known):_____

4. Etiology of hearing loss (if known): _____

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To obtain this information in a different format, call: 651-201-3650