TORONTO Public Health

early abilities
tph.to/earlyabilities

Infant Hearing Program
Tel: 416-338-8255
TTY: 416-338-0025
Fax: 416-696-4205

AUDIOLOGY COCHLEAR IMPLANT EVALUATION SUMMARY

Child's Name: Last First	**Primary Contact** (Parent/Legal Guardian) **CAS** ☐ Last First
Year Month Day **DOB:** __ __ __ __ / __ __ / __ __ **GA:** ___ (wks)	**Residential Address:** No Change ☐
Gender: **M** ☐ **F** ☐	Street Address
Service Language: English ☐ French ☐ Other:_____	City Postal Code Previous address if moved: _____
Language Interpreter needed:_____	Home Phone / Other Phone
Has sibling identified with PHL? Yes ☐ No ☐ Unknown ☐	Primary Care Physician **(if known):** No Change ☐

COCHLEAR IMPLANT EVALUATION DETAILS

Cochlear Implant	Switch-on Date
Right ear	☐ Date: __ __ __ __ / __ __ / __ __ YYYY MM DD
Left Ear	☐ Date: __ __ __ __ / __ __ / __ __ YYYY MM DD

CONSENT HAS BEEN OBTAINED TO SHARE INFORMATION WITH IHP FOR FOLLOW UP: **Yes** ☐ **No** ☐

Comments: _____

_____

_____

_____

Testing Audiologist (Print): _____
(Last name, First name)

Signature: _____

Telephone No: (416) 813-7259

Location: Hospital For Sick Children

Date Of Test: __ __ __ __ / __ __ / __ __
YYYY MM DD

Future Audiology Assessment Date: __ __ __ __ / __ __ / __ __
YYYY MM DD

Personal information contained on this form is collected under the authority of The Health Protection and Promotion Act, R.S.O. 1990, c. H. 5 and is used by the Infant Hearing Program for follow-up and support services. Questions about this form should be directed to: Early Abilities Manager, Infant Hearing Program, Child Health and Development, 225 Duncan Mill Rd, Suite 201, Toronto, ON, M3B 3K9 or by telephone: 416-338-8255.

TORONTO Public Health

early abilities
tph.to/earlyabilities

Infant Hearing Program
Tel: 416-338-8255
TTY: 416-338-0025
Fax: 416-696-4205

HIGH RISK SURVEILLANCE SUMMARY

☐ New to IHP

Child's Name: Last First	**Primary Contact** (Parent/Legal Guardian)**:** Last First ☐ **CAS**
DOB: / / (YYYY MM DD) **GA:** (wks)	**Residential Address:** Street Address ☐ ****NEW****
Gender: ☐ Male ☐ Female	**City** **Postal Code**
Service Language: ☐ English ☐ French ☐ Other:	**Previous address if moved:**
Language Interpreter needed:	**Home Phone:** **Other Phone:**
Has sibling identified with PHL? ☐ Yes ☐ No ☐ Unknown	**Email Address:** ☐ Consent for email communication
Consent to share information with IHP for follow up: ☐ Yes ☐ No	**Primary Care Physician:**

AUDIOLOGY SURVEILLANCE OUTCOME		
Risk Factor:		
Protocol: ☐ Standard ☐ Intensive	**Method:** ☐ ABR ☐ VRA ☐ PLAY	
	Left Ear	**Right Ear**
Pass	☐	☐
Refer	☐	☐
No Result/CNC	☐	☐
Communication Checklist	☐ Passed ☐ Referred to PSL ☐ Did not complete	

NEXT STEP (CHOOSE ONE)	
Additional Audiology Surveillance	☐ ABR ☐ VRA ☐ PLAY
Move to Audiology Assessment	☐
Move to: ☐ **18 mo Surv Questionnaire** ☐ **30 mo Surv Questionnaire**	Due: / (YYYY MM)
Discharge from Infant Hearing	☐ No additional surveillance required ☐ Not at risk (details in Notes) ☐ No contact letter sent: / / (YYYY MM DD)

NOTES:

Audiologist: Last Name, First Name	**Location:**
Date: / / (YYYY MM DD)	**Future Appt Date:** (or recommended year and month) / / (YYYY MM DD)

TORONTO Public Health

early abilities
tph.to/earlyabilities

Infant Hearing Program
Tel: 416-338-8255
TTY: 416-338-0025
Fax: 416-696-4205

AUDIOLOGY ASSESSMENT / HEARING AID EVALUATION OR RECHECK

☐ New to IHP

Child's Name: Last Name First Name	**Primary Contact:** Last Name First Name ☐ **CAS**
DOB: / / (YY MM DD) **GA:** (wks)	**Residential Address:** Street Address ☐ ****NEW****
Gender: ☐ M ☐ F **Risk Factor:** ☐ Yes ☐ No	City Postal Code
Service Language: ☐ English ☐ French ☐ Other:	**Previous address if moved:**
Language Interpreter needed: ☐ Yes ☐ No	**Home Phone:** **Other Phone:**
Has sibling identified with PHL? ☐ Yes ☐ No ☐ Unknown	**Email Address:** ☐ Consent for email communication
Consent to share information with IHP for follow up: ☐ Yes ☐ No	**Primary Care Physician:**

Comorbidities:
☐ Autism ☐ Cerebral Palsy
☐ Syndrome ☐ Impaired Vision
☐ Other (specify):

Complex Factors:
☐ Delayed Fitting ☐ Inconsistent Hearing Aid Use
☐ Middle Ear Dysfunction ☐ Late Identification
☐ Unreliable Respondent ☐ Other (specify):

ASSESSMENT RESULTS: ☐ **ABR (dBeHL)** ☐ **VRA (dBHL)** ☐ **Play (dBHL)** ☐ **Conventional (dBHL)**

LEFT EAR AIR	LEFT EAR BONE	FREQ (kHz)	RIGHT EAR AIR	RIGHT EAR BONE
		0.5		
		1.0		
		2.0		
		4.0		

HEARING LOSS TYPE		
☐	Sensorineural	☐
☐	Conductive	☐
☐	Mixed	☐
☐	Unknown	☐
☐	None	☐

HL	PHL	HRG LOSS	HL	PHL
☐	☐	Yes	☐	☐
☐	☐	No	☐	☐
☐	☐	CNC	☐	☐

AUDITORY NEUROPATHY SPECTRUM DISORDER		
☐	Definite	☐
☐	Suspected	☐
☐	Not Suspected	☐

LITTLEARS AUDITORY QUESTIONNAIRE

☐ Electronically	☐ Interview—interpreter
☐ Independently in office	☐ Mail
☐ Interview—1° caregiver	☐ Telephone
☐ Interview—family/friend	☐ Other:
Tool #:	**Score:**

LEFT HEARING AID	RIGHT HEARING AID
☐ New Prescription ☐ Recheck ☐ N/A	☐ New Prescription ☐ Recheck ☐ N/A
Hearing Aid Model: ☐ No Change	Hearing Aid Model: ☐ No Change ☐ Same as Left
☐ AC ☐ BC ☐ CROS ☐ Own ☐ Loaner	☐ AC ☐ BC ☐ CROS ☐ Own ☐ Loaner
RECD: ☐ Measured ☐ Predicted ☐ Used other ear values ☐ Used previously measured values	RECD: ☐ Measured ☐ Predicted ☐ Used other ear values ☐ Used previously measured values
MPO Measured: ☐ Yes ☐ No	MPO Measured: ☐ Yes ☐ No
SII: Soft (55 dB): Avg (65 dB):	SII: Soft (55 dB): Avg (65 dB):

LEFT EAR FM	NON SPECIFIC FM	RIGHT EAR FM
☐ New Rec ☐ In Use ☐ N/A	☐ New Rec ☐ In Use ☐ N/A	☐ New Rec ☐ In Use ☐ N/A
For: ☐ Home ☐ School ☐ Personal FM + HA ☐ Ear Level FM only	For: ☐ Home ☐ School ☐ Soundfield ☐ Portable Speaker	For: ☐ Home ☐ School ☐ Personal FM + HA ☐ Ear Level FM only

NEXT STEP: (TICK ALL THAT APPLY)

Move to Surveillance: ☐ VRA/PLAY ☐ Questionnaire	/ / (YY MM DD)
Medical referral to physician	/ / (YY MM DD)
Medical referral to ENT requested	/ / (YY MM DD)
Referral to IHP Social Worker in local region	☐ Yes ☐ No ☐ Done
Referral for Communication Development Services:	☐ ASI ☐ ASL ☐ SLI
Communication Development Plan Completed	☐ Yes ☐ In Progress ☐ No
Recommendation for Assistive Technology	☐ HA ☐ CI ☐ FM ☐ Done
Referral for consult for sedated ABR	☐
Transfer To:	☐
Discharge from Audiology	☐

NOTES:

Audiologist: _____ **Location:** _____

Date Of Test: YY MM DD **Future Appt:** YY MM DD

OUT OF REGION AUTHORIZATION

NOTES:
☐ Declined
☐ Approved
☐ Expires YY MM DD