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PHYSICIAN'S REPORT OF HEARING EVALUATION

Student Name________________________________ Date of Birth__________________

Examination Date____________________________

RESULTS OF THRESHOLD HEARING TESTS

RIGHT EAR						
250	500	1000	2000	4000	8000	Pass (P) or Fail (F)

LEFT EAR						
250	500	1000	2000	4000	8000	Pass (P) or Fail (F)

Physician's Audiogram Attached? YES NO

Tentative Diagnosis:____

Type of Hearing Loss:____

Prognosis:____

____

____

Recommendations:____

____

____

Physician's Signature______________________________

Physician's Name (Printed):______________________________

Address: ______________________________

____

Telephone No. (   )______________________________