BETHEL SCHOOL DISTRICT #403
HEARING SCREENING REFERRAL FORM

Student's Name _____ Birthdate _____ Sex _____

School _____ Grade _____ Teacher _____

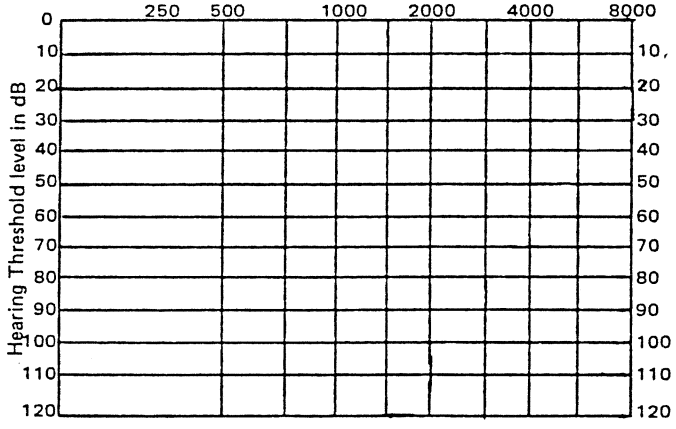
Your child participated in a hearing screening test conducted on (date) _____, and a re-evaluation on (date) _____ . The results of both tests, shown below indicate that your child should be examined by your family physician or attending physician at one of the Pierce County Health Clinics, for a suspected hearing loss. Show these test results to the examining doctor. It is requested that you return this report to the school so that it can be made a permanent part of the school health record. If you have any questions regarding this referral, please call school health record. If you have questions regarding this referral, please call _____ . Thank you.

_____
Name and Position

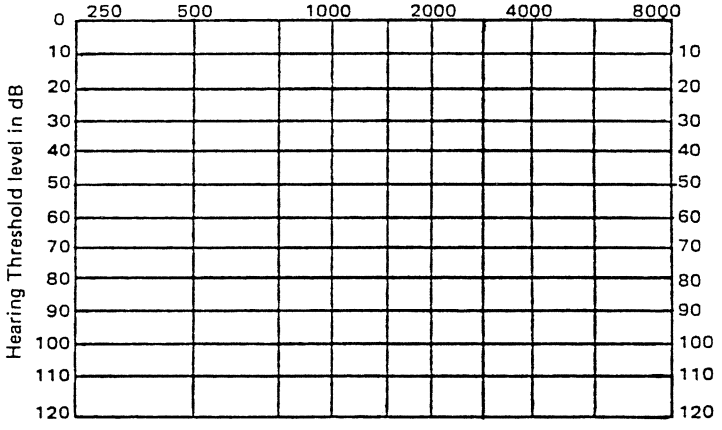
DO NOT DETACH

Air Conduction: Right: Red 0 - Left: Blue X

TEST I



TEST II



Date _____ Date _____

Impressions and Recommendation: _____

_____

Physician's Report: (Please return information to school) Diagnosis: _____

_____

Recommendations: _____

_____

Physician's Signature _____ Date _____

30-HS-3 ncr 6/04