

Promoting wellness. Ensuring	g care.	PHONE:	FAX:
AUDIOLOGY ASSES	SMENT		
Name:		PARIS ID:	Assessment Date:
Preferred:		PHN:	
DOB:	Age:	Phone:	
Gender:	7.90.	Physican:	
Home Address:		School:	
EHP Patient			
☐ EHP PATIENT	■ NON-EHP PATIENT	EHP Number:	EHP Discharge Date:
Hearing Risk Factors			
Hearing Risk Factor		Comments	
Background Information			
☐ Hearing concerns at home			
☐ Hearing concerns at school			
☐ History of middle ear problems			
Dizziness			
Tinnitus			
Follow up from newborn hearing	g screening		
School screening follow-up			
Speech-language concern			
Review of hearing status: Known hearing loss:			
Hearing equipment			
☐ Hearing aids:			
FM equipment:			
Other: Comments:			
Comments.			
Results			
Result Status:		Ear Specificity:	
Soundfield Result:			
RIGHT		LEFT	
Degree:	То:	Degree:	То:
Туре:		Туре:	
Overall Result:		Overall Result:	
Course:		Course:	

Configuration:

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Configuration: Comments:

AUDIOLOGY ASSESSMENT						
Name:			PARIS ID:			
Tests Conducted						
Otoscopy Middle Ear	Beh - fz	☐ Beh	- bb	OAEs	☐ ABR	☐ ASSR
Otoscopy						
Unremarkable			LEFT			
Excessive ear wax: Non-occluding	RIGHT		LEFT			
Excessive ear wax: Occluding	RIGHT		LEFT			
Ventilation tube extruded	RIGHT		LEFT			
Ventilation tube in situ	RIGHT		LEFT			
Attempted but not successful (RIC	GHT)	Atten	npted but not succ	cessful (LEFT)		
Comments:						
Middle Ear			Attornated but no	t avecage.il		
Attempted but not successful			Attempted but no	it successiui	Ш	
RIGHT			LEFT			
Tympanogram Frequency:	daPa		Tympanogram F			daPa
Middle ear pressure:			Middle ear press			
Static admittance:	ml		Static admittand			ml
Ear canal volume:	ml		Ear canal volum			ml
Interpretation of tympanogram:			Interpretation of	tympanogram	:	
Acoustic Reflex Screening						
Right:			Left:			
Diagnostic Acoustic Reflex:						
Comments:						

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Name:		PARIS ID:			
Behavioural					
Frequency-Specific Stimu	li				
Assessed By		Stimulus Type	Stimulus Type		
Behavioural Observa	ation Audiometry (BOA)	☐ Narrow Band No	☐ Narrow Band Noise (NBN)		
☐ Visual Reinforcemer		☐ Pure Tone	☐ Pure Tone		
☐ Conditioned Play Au		☐ Warble Tone	☐ Warble Tone		
Conventional Audior					
Ear Specificity:		Transducer:			
RIGHT		LEFT			
☐ Attempted but not successful		Attempted but not successful			
500 Hz		500 Hz			
A/C	dBHL	A/C	dBHL		
B/C	dBHL	B/C	dBHL		
1 kHz		1 kHz			
A/C	dBHL	A/C	dBHL		
B/C	dBHL	B/C	dBHL		
2 kHz		2 kHz			
A/C	dBHL	A/C	dBHL		
B/C	dBHL	B/C	dBHL		
4 kHz		4 kHz			
A/C	dBHL	A/C	dBHL		
B/C	dBHL	B/C	dBHL		
Reliability:					
Localization:					
Comments:					

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Name:	PARIS ID:			
Broadband Stimuli				
Assessed By	Stimulus Type			
☐ Speech Awareness Threshold (SAT)	Music			
☐ Speech Reception Threshold (SRT)	☐ Recorded voice			
	Live voice			
	Other Specify:			
Ear Specificity:	Transducer:			
RIGHT	LEFT			
Attempted but not successful	Attempted but not successful			
MRL (A/C)	MRL (A/C)			
MRL (B/C)	MRL (B/C)			
Reliability:				
☐ Speech threshold(s) consistent with frequency specific findings				
Comments:				
Word recognitition testing:				
Otoacoustic Emissions				
DOPAE vs TEOAE:	DOPAE vs TEOAE:			
RIGHT	LEFT			
Attempted but not successful	☐ Attempted but not successful			
Reproducibility % (when TEOAE):	Reproducibility % (when TEOAE):			
Response replication (when DPOAE): Response replication (when DPOAE):				
Patient State:	Patient State:			
2000Hz:	2000Hz:			
3000Hz:	3000Hz:			
4000Hz:	4000Hz:			
Interpretation consistent with:				
Right:	Left:			
Comments:				

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Name:			PARIS ID:			
ABR						
Transducer:			Reliability:			
RIGHT		CORRECTION	LEFT			
Attempted but not suc	ccessful	FACTOR	FACTOR Attempted but not successful			
500 Hz			500 Hz			
A/C	dBnHL	-15	A/C	dBnHL		
B/C	dBnHL	n/a	B/C	dBnHL		
1 kHz			1 kHz			
A/C	dBnHL	-10	A/C	dBnHL		
B/C	dBnHL	n/a	B/C	dBnHL		
2 kHz			2 kHz			
A/C	dBnHL	-5	A/C	dBnHL		
B/C	dBnHL	n/a	B/C	dBnHL		
4 kHz			4 kHz			
A/C	dBnHL	0	A/C	dBnHL		
B/C	dBnHL	n/a	B/C	dBnHL		
NEUROLOGIC INDICATORS						
RIGHT			LEFT			
☐ Did not test neurologic indicators		☐ Did not test neurologic indicators				
☐ Wave V clearly present		☐ Wave V clearly present				
☐ Degraded wave V present		☐ Degraded wave V present				
Absent neural waveforms		Absent neural waveforms				
☐ Present CM		☐ Present CM				
☐ VIIIth N Brainstem dysfunction		☐ VIIIth N Brainstem dysfunction				
Comments:						

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Reliability:	Name:			PARIS ID:	
RIGHT	ASSR				
Attempted but not successful Attempted but not successful 500 Hz	Transducer:			Reliability:	
500 Hz AC dBHL AC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL AIC dBHL BIC BIL BIC BIC BIL BIC <	RIGHT			LEFT	
AVC dBHL AVC dBHL BIC dBHL BIC dBHL 1 kHz AVC dBHL AVC BIC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL BIC dBHL AVC dBHL AVC dBHL BIC DBL BVE BVE BIC DBL BVE BVE BIC DBL BVE BVE BIC BVE BVE BVE BIC BVE	Attempted but not successf	ful		Attempted but not successful	
BIC dBHL BC d	500 Hz			500 Hz	
1 kHz AC dBHL AC dBHL BC dBHL BC dBHL BC dBHL BC dBHL AC dBHL AC dBHL AC dBHL BC dBHL AC dBHL AC dBHL AKHz AKHz AKHz AC dBHL AC dBHL AC dBHL AC dBHL AC dBHL AC dBHL AC AC dBHL AC	A/C	dBHL		A/C	dBHL
A/C dBHL A/C dBHL B/C dBHL B/C dBHL 2 kHz A/C dBHL A/C dBHL B/C dBHL B/C dBHL A/C dBHL 4 kHz A/C dBHL B/C dBHL A/C dBHL A/C A/C <td< th=""><th>B/C</th><th>dBHL</th><th></th><th>B/C</th><th>dBHL</th></td<>	B/C	dBHL		B/C	dBHL
BIC	1 kHz			1 kHz	
2 kHz AC	A/C	dBHL		A/C	dBHL
A/C dBHL A/C dBHL B/C dBHL B/C dBHL 4 kHz 4 kHz dBHL A/C dBHL B/C dBHL B/C dBHL Comments: Equipment Recorded By: Date Recorded By: Date Recorded By: Date Recorded: Equip Type: Repair Co.: Equip Type: Repair Co.: Equip Item: Vendor: Funding Source: If Other, Specify: DF unding Source: Urgency: Serial No.: Purchase/Loan/Rent: Replacement Value: Equip Mods.: Date Requested: Date Requested: Period Of Loan (Weeks): Date Requested: Period Of Loan (Weeks): Date Requested: Date	B/C	dBHL		B/C	dBHL
BIC dBHL 4 kHz 4					
4 kHz A/C dBHL A/C dBHL dBHL <td< th=""><th></th><th></th><th></th><th></th><th></th></td<>					
A/C dBHL A/C dBHL B/C		dBHL			dBHL
### ACC GBHL					ADUI
Equipment Recorded By: Team: Equip Type: Equip Type: Equip I Type: Equip Source: If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Requested: Date Requested: Period Of Loan (Weeks): Date Received: Review Usage On: Client/Caregiver Competent with Equipment Date Equip Returned: Date Equip Returned:					
Equipment Recorded By: Team: Equip Type: Equip Type: Equip Source: If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Requested: Date Requested: Period Of Loan (Weeks): Date Received: Review Usage On: Date Equipment Date Equip Returned:	B/C	dBHL		B/C	dBHL
Recorded By: Team: Equip Type: Equip Type: Equip Item: Funding Source: If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Requested: Date Requested: Date Requested: Date Recorded: No Longer Applicable Date Review Usage On: Client/Caregiver Competent with Equipment Date Recorded: Date Recorded: Date Recorded: Repair Co.: Repair Co.: Acpair	Comments:				
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Team: Equip Type: Repair Co.: Equip Item: Vendor: Funding Source: If Other, Specify: ID Funding Source: Serial No.: Purchase/Loan/Rent: Replacement Value: GF Strong ATSS Number: Equip Mods.: Date Requested: Period Of Loan (Weeks): Date Received: No Longer Applicable Review Usage On: Client/Caregiver Competent with Equipment Date Equip Returned:				Date Recorded:	
Equip Type: Equip Item: Funding Source: If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Requested: Date Requested:				Date Recorded.	
Equip Item: Funding Source: If Other, Specify: ID Funding Source: Urgency: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Requested: Period Of Loan (Weeks): Date Received: Review Usage On: Client/Caregiver Competent with Equipment Vendor: Vendor: Urgency: Purchase/Loan/Rent: GF Strong ATSS Number: Period Of Loan (Weeks): Due Return Date: Client/Caregiver Competent with Equipment Date Equip Returned:				Renair Co.:	
Funding Source: If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Received: Review Usage On: Client/Caregiver Competent with Equipment Urgency: Urgency: GF Strong ATSS Number: Period Of Loan (Weeks): No Longer Applicable Date Equip Returned:					
If Other, Specify: ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Received: Review Usage On: Client/Caregiver Competent with Equipment Urgency: Urgency: Purchase/Loan/Rent: GF Strong ATSS Number: Period Of Loan (Weeks): No Longer Applicable Date Equip Returned:				vendor.	
ID Funding Source: Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Received: Review Usage On: Client/Caregiver Competent with Equipment Urgency: Purchase/Loan/Rent: GF Strong ATSS Number: Period Of Loan (Weeks): No Longer Applicable Date Equip Returned:	-				
Serial No.: Replacement Value: Equip Mods.: Date Requested: Date Received: Review Usage On: Client/Caregiver Competent with Equipment Purchase/Loan/Rent: GF Strong ATSS Number: Period Of Loan (Weeks): No Longer Applicable Due Return Date: Date Equip Returned:				Hamana	
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Date Received: No Longer Applicable Review Usage On: Due Return Date: Client/Caregiver Competent with Equipment □ Date Equip Returned:	Equip Mods.:				
Date Received: No Longer Applicable Review Usage On: Due Return Date: Client/Caregiver Competent with Equipment □ Date Equip Returned:					
Date Received: No Longer Applicable Review Usage On: Due Return Date: Client/Caregiver Competent with Equipment □ Date Equip Returned:	Date Requested:			Period Of Loan (Weeks):	
Review Usage On: Client/Caregiver Competent with Equipment Due Return Date: Date Equip Returned:			_		
Client/Caregiver Competent with Equipment Date Equip Returned:					
Comments:			Date Equip Returned:		
	Comments:				

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AUDIOLOGI AUGLOGINILITI		
Name:	PARIS ID:	
General Amplification Comments		
Hearing Aid Verification		
Assessed By:	Date Assessed:	
Test:		
Comments:		
Summary		
Hearing normal bilaterally		
Hearing sufficient for normal speech and language development		
Hearing adequate for listening needs at home and at school		
No significant change since last hearing assessment		
Comments:		
BCEHP Recommendations		
Medical Referral		
Expedited Medical ReferralAmplification Device Referral		
☐ Amplification Device Referral☐ Audiologocial monitoring		
	Desagram	
Early intervention referral has been made through the BC Early HearingDischarge from BCEHP	Program	
☐ Discharge from BCEHP		

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Name:	PARIS ID:			
Non-EHP Recommendations				
☐ Medical consultation				
☐ Check middle ear status				
☐ Cerumen management				
Rule out any medical concerns related to	hearing loss			
 Otological evaluation should be consider 	ed - referral to Otolaryngologist/ENT			
	T for legally required clearance to fit amplification			
Ongoing medical monitoring regarding m				
· · · · · · · · · · · · · · · · · · ·	o refer to BC Chidlren's Hospital for Sedated Auditory Brainstem Response Test			
	ontact of teacher's face and away from noise sources			
☐ Hearing aids Right:				
Left:				
Consider for Hearing Resource Teacher Services				
Referral to Community Speech Language Pathology				
Consider for school based Speech-Language service	es			
Personal FM Equipment:				
Soundfield FM Equipment:				
Monitoring of hearing status	W			
Audiology review date:	If exact date not known:			
School hearing screening date:	If exact date not known:			
☐ Discharge; review on request Comments:				
Comments.				
Signature:				
-				
Note: Once downtime informati	on from this form has been entered in PARIS, shred this working sheet.			
End of Report				

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