



SCREENING

Enter all screening data by preschool, in line a, and by school age, in lines b-o. All full-time special education class children must be entered on line o.

Column

1. **NUMBER SCREENED.** Enter the total number of children screened.
2. **NUMBER RESCREENED.** Enter the total number of children rescreened.
3. **NUMBER OF THRESHOLDS.** Enter the total number of children who received threshold tests following second screening test failure. Include children upon whom you attempted thresholds, but were unable to obtain conclusive results.
4. **THRESHOLDS: KNOWN CASES AND MONITORING.** Enter the total number of thresholds on children considered as known cases, e.g., children from watch lists, under physicians care, with hearing aids, etc.
5. **NUMBER REFERRED.** Enter the total number of children who met medical referral criteria and/or were referred because of obvious symptoms of ear pathology (i.e., draining ears).

Add the data entered in each column, 1 through 5, and enter these sums on line p.

FOLLOW-UP RESULTS

Enter all follow-up results by school age, in column 6, and preschool, in column 7. Enter the sums of lines q and r in column 8. Add columns 6, 7 and 8 and enter on line s. The sums of column 8 and line s must be equal and the number entered in cell 8-s must equal the total number of children referred, cell 5-p.

Number of Completed Medical Referrals (q). Enter the total number of children for whom a treating physician's report has been returned or information has been obtained verifying examination and diagnosis by a physician.

Number of Referrals Not Completed (r). Enter the total number of children for whom **no** treating physician's report has been received or information obtained verifying a medical examination and diagnosis.



DIAGNOSIS

Enter all diagnostic data by school age, column 6, and preschool, column 7. Enter the sums of line t through z in column 8. Add columns 6, 7 and 8 and enter on line aa. The sums of column 8 and line aa must be equal and the number entered in cell 8-aa must equal the number of completed medical referrals, cell 8-q.

Total Number of Children Found to Have. Enter the total number of children with a physician's diagnosis on the following lines:

A. CONDUCTIVE LOSSES

1. Canal obstructions (t)
2. Otitis Media (u)
3. Other (This classification includes allergies, cholesteatoma, otosclerosis, etc.) (v)

B. NON-ORGANIC (w). Children diagnosed with a non-specific hearing loss (no definitive pathology or specific cause indicated).

C. SENSORINEURAL (x). Children diagnosed with a sensorineural loss (cochlear or eighth cranial nerve).

D. MIXED (y). Children diagnosed with both a conductive and sensorineural hearing loss.

E. NORMAL FINDINGS (z). Children diagnosed as normal hearing or for whom there is no pathological finding.

PROGRAM

Print or type agency name, i.e., school district name and number, health department name or **other** agency name. Print or type agency address: number and street, city, ZIP code and county. Enter the name, e-mail and telephone number of the individual submitting the report. Enter the date the report is submitted.

Submit one cumulative annual report from each school district, health department or other agency responsible for hearing screening.

Submit this report to the Illinois Department of Public Health's Vision and Hearing Program by June 30 of each year.

TYPE OR PRINT LEGIBLY. CHECK ALL COMPUTATIONS. THIS FORM IS USED TO COMPILE STATEWIDE STATISTICS. THANK YOU FOR YOUR COOPERATION.



This document contains preliminary information.

		1	2	3	4	5	FOLLOW-UP RESULTS			
		Number Screened	Number Rescreened	Number of Thresholds	Thresholds: Known Cases and Monitoring	Number Referred	School-age	Pre-school	Total	
a	Preschool						q	Number of completed referrals		
b	K						r	Number of referrals not completed		
c	1						s	Total		
d	2						DIAGNOSIS			
e	3									
f	4									
g	5						Total number of children found to have			
h	6						t	A. Conductive losses		
i	7						u	1. Canal obstruction		
j	8						v	2. Otitis Media		
k	9						w	3. Other		
l	10						x	B. Non-Organic		
m	11						y	C. Sensorineural		
n	12						z	D. Mixed		
o	Sp.Ed						aa	E. Normal Findings		
p	TOTAL						aa	TOTAL		
							Program Name			Dist.#
							Address			
Submit by June 30							City		ZIP Code	
Fax 217-524-4201 or Illinois Department of Public Health Vision and Hearing Section 535 W. Jefferson St., Third Floor Springfield, IL 62761							County			
							Submitted By			
							Phone Number (of submitter)		Date	
							E-mail Address			

SUBMIT **ONE** ANNUAL SUMMARY FOR HEARING PER SCHOOL DISTRICT (OR HEALTH DEPARTMENT PER COUNTY).