

Illinois Department of Public Health
TREATING PHYSICIAN'S REPORT

Name	Date of Birth / /	Screening Program
Parent's Name	Screening Location	
Street Address	Referred By	
City	County	

EAR EXAMINATION

<p>AUDITORY CANAL</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">R</td> <td style="width: 50%;">L</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>NO FINDINGS</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>FINDINGS →</td> </tr> </table>	R	L		<input type="checkbox"/>	<input type="checkbox"/>	NO FINDINGS	<input type="checkbox"/>	<input type="checkbox"/>	FINDINGS →	<p>OCCLUDED</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">R</td> <td style="width: 50%;">L</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>PARTIALLY</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>COMPLETELY</td> </tr> </table>	R	L		<input type="checkbox"/>	<input type="checkbox"/>	PARTIALLY	<input type="checkbox"/>	<input type="checkbox"/>	COMPLETELY	<p>OCCLUDED BY</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">R</td> <td style="width: 50%;">L</td> <td style="width: 50%;">R</td> <td style="width: 50%;">L</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>CERUMEN</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>FOREIGN BODY</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>INFLAMMATION</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>OTHER (DESCRIBE)</td> </tr> </table>	R	L	R	L		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CERUMEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOREIGN BODY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INFLAMMATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (DESCRIBE)													
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NOSE AND THROAT EXAMINATION

<p>TONSILS</p> <p><input type="checkbox"/> REMOVED COMPLETELY</p> <p><input type="checkbox"/> TONSILS PRESENT (NORMAL)</p> <p><input type="checkbox"/> TONSILS PRESENT (ENLARGED)</p>	<p>ORAL PHARYNX</p> <p><input type="checkbox"/> NO FINDINGS</p> <p><input type="checkbox"/> CLEFT PALATE</p> <p><input type="checkbox"/> REPAIRED <input type="checkbox"/> UNREPAIRED</p> <p><input type="checkbox"/> POSTNASAL DISCHARGE</p> <p><input type="checkbox"/> MOUTH BREATHING</p> <p><input type="checkbox"/> OTHER (DESCRIBE)</p>
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DIAGNOSIS

<p><input type="checkbox"/> CANAL OBSTRUCTIONS</p> <p><input type="checkbox"/> SERIOUS OTITIS MEDIA</p> <p><input type="checkbox"/> DRUM PERFORATION</p> <p><input type="checkbox"/> ALLERGIES</p> <p><input type="checkbox"/> OTHER (DESCRIBE) _____</p> <p>_____</p>	<p><input type="checkbox"/> CONDUCTIVE HEARING LOSS</p> <p><input type="checkbox"/> SENSORI-NEURAL HEARING LOSS</p> <p><input type="checkbox"/> CONFIRMED BY BONE CONDUCTION AUDIOMETRY</p> <p><input type="checkbox"/> CONFIRMED BY TUNING FORK</p> <p><input type="checkbox"/> MIXED HEARING LOSS</p> <p><input type="checkbox"/> OTHER (DESCRIBE) _____</p> <p>_____</p>
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COMMENTS

TREATMENT

I SUGGEST A REPEAT AUDIOGRAM IN _____ WEEKS.

<p>RELEASE OF INFORMATION</p> <p>CONSENT OF PARENT OR GUARDIAN</p> <p>I agree to release the above information on my child or ward to appropriate health and/or school authorities.</p> <p>_____</p> <p style="text-align: center;">SIGNATURE OF PARENT OR GUARDIAN</p>	<p>Date of Examination / /</p> <p>Stamp or Print Physician's Name</p> <p>Address</p> <p>_____</p> <p>_____</p>
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PLEASE RETURN THIS FORM TO _____
 NAME OF SCHOOL