**Insert logo and address here**

**Hearing Referral Form**

**Primary Care Provider**

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian of Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_, Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_:

As you know, all children participating in our program receive a hearing screening. We are pleased to offer this as a helpful resource in caring for your child’s hearing health.

The results of your child’s hearing screening are as follows:

**Your Child’s Left Ear:**

**Your Child’s Right Ear:**

After reviewing your child's hearing screening results, we are recommending that a more detailed examination be scheduled with a doctor. Some children may not pass the hearing screening due to wax blockage in the ear canal or a mild, undetected middle ear infection. It is therefore important that your child’s ears be examined by a doctor as soon as possible.

At this time, we are referring your child to his/her primary care provider for a follow-up exam. Please make an appointment as soon as possible. If you have questions or concerns, please call us at \_\_\_\_\_\_\_.

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Let us know if you need any help in making this follow-up appointment.

Sincerely,

\_\_\_\_\_\_\_\_\_