

Hearing Evaluation Report

Name: _____ Date of Evaluation: _____
Date of Birth: _____ Gender: _____ Address: _____
Parents: _____ Contact Phone: _____
Supervisor: _____ Clinician(s): _____

I. Statement of Problem and Referral

II. History

III. Evaluation Results

- A. Outer Ear Status
- B. Middle Ear Status
- C. Inner Ear Status
- D. Retrocochlear Status
- E. Hearing Sensitivity
- F. Speech Recognition Ability
- G. Hearing Aid Candidacy

IV. Diagnostic Summary

V. Recommendations

If you have any questions about this report, contact the clinic at 573-651-2050.

Kevin Squibb, PhD, CCC-A
Supervising Faculty Audiologist

Susie Smith, MA
Graduate Clinician