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

AUDITORY CANAL

R	L	
☐	☐	NO FINDINGS
☐	☐	FINDINGS →

OCCLUDED

R	L	
☐	☐	PARTIALLY
☐	☐	COMPLETELY

OCCLUDED BY

R	L		R	L	
☐	☐	CERUMEN	☐	☐	INFLAMMATION
☐	☐	FOREIGN BODY	☐	☐	OTHER (DESCRIBE)

DRUM

R	L	
☐	☐	NO FINDINGS
☐	☐	FINDINGS →
☐	☐	NOT VISIBLE

R	L		R	L	
☐	☐	DULL	☐	☐	SCARS
☐	☐	BULGING	☐	☐	OPAQUE
☐	☐	RETRACTED	☐	☐	RED
☐	☐	PERFORATED	☐	☐	OTHER (DESCRIBE)

NOSE AND THROAT EXAMINATION

TONSILS

- ☐ REMOVED COMPLETELY
- ☐ TONSILS PRESENT (NORMAL)
- ☐ TONSILS PRESENT (ENLARGED)

ORAL PHARYNX

- ☐ NO FINDINGS
- ☐ CLEFT PALATE
- ☐ REPAIRED ☐ UNREPAIRED
- ☐ POSTNASAL DISCHARGE
- ☐ MOUTH BREATHING
- ☐ OTHER (DESCRIBE)

DIAGNOSIS

- ☐ CANAL OBSTRUCTIONS
- ☐ SEROUS OTITIS MEDIA
- ☐ DRUM PERFORATION
- ☐ ALLERGIES
- ☐ OTHER (DESCRIBE) ____________________
- ☐ CONDUCTIVE HEARING LOSS
- ☐ SENSORI-NEURAL HEARING LOSS
  - ☐ CONFIRMED BY BONE CONDUCTION AUDIOMETRY
  - ☐ CONFIRMED BY TUNING FORK
- ☐ MIXED HEARING LOSS
- ☐ OTHER (DESCRIBE) ____________________

COMMENTS

TREATMENT

I SUGGEST A REPEAT AUDIOGRAM IN ________ WEEKS.

RELEASE OF INFORMATION

CONSENT OF PARENT OR GUARDIAN

I agree to release the above information on my child or ward to appropriate health and/or school authorities.

SIGNATURE OF PARENT OR GUARDIAN

Date of Examination / /

Stamp or Print Physician's Name

Address

IL 482-0638

PLEASE RETURN THIS FORM TO ____________________

NAME OF SCHOOL