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
- ☐ ☐ CERUMEN
- ☐ ☐ FOREIGN BODY
- ☐ ☐ INFLAMMATION
- ☐ ☐ OTHER (DESCRIBE)

DRUM

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

R L
- ☐ ☐ DULL
- ☐ ☐ BULGING
- ☐ ☐ RETRACTED
- ☐ ☐ PERFORATED

R L
- ☐ ☐ SCARS
- ☐ ☐ OPAQUE
- ☐ ☐ RED
- ☐ ☐ 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
- ☐ SERIOUS 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 482-0838

PLEASE RETURN THIS FORM TO _____
NAME OF SCHOOL