

Audiometry - New Forms for use by Community Nurses in NSW Health Hearing Clinics

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Functional Sub group Clinical/ Patient Services - Information and data
Clinical/ Patient Services - Records

Summary Revised forms produced by the Community Nurse Audiometrist Association Inc are endorsed for use in NSW Health Hearing Clinics from 1 October 2005. Hearing Clinics conducted by Nurse Audiometrists are required to use these revised forms. Health Services using these revised forms will be charged for the cost of producing the forms.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Community Health Centres, Public Hospitals

Audience All clinical and administration staff

Distributed to Public Health System, Community Health Centres, Divisions of General Practice, Government Medical Officers, NSW Department of Health, Public Hospitals, Private Hospitals and Day Procedure Centres

Review date 01-Sep-2010

File No. 02/5094

Previous reference N/A

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

Audiometry - New forms for use by Community Nurses in NSW Health Hearing Clinics

The Community Nurse Audiometrists Association Inc. recently conducted a review of the Audiometry forms used by Nurse Audiometrists in NSW Health Hearing Clinics.

This review was prompted by:

- Changes to the equipment used to conduct audiometric assessment
- A need to collect more detailed case history information than currently recorded
- Requests from Nurse Audiometrists for more “user-friendly” forms
- The introduction of the Statewide Infant Screening – Hearing (SWISH) program

This review indicated that amendments were required to the existing nurse audiometry report forms for improved functionality and elimination of redundant information.

Following consultation with relevant stakeholders, amendments were made to the **Audiometry Report Form (CH5A)** and the **Audiometry History Form (CH5B)** samples attached.

These amended audiometry forms are approved for use in NSW Health Hearing Clinics and all NSW Health Nurse Audiometrist Hearing Clinics are required to use these amended forms from 1 October 2005.

The CH5A and CH5B forms are no longer available free of charge from the Better Health Centre. Area Health Services will be charged for the forms, which can be ordered from:

Salmat (incorporating GPS)
Locked Bag 20
Moorebank NSW 2170
Telephone (02) 9743 8777
Facsimile (02) 9743 8603

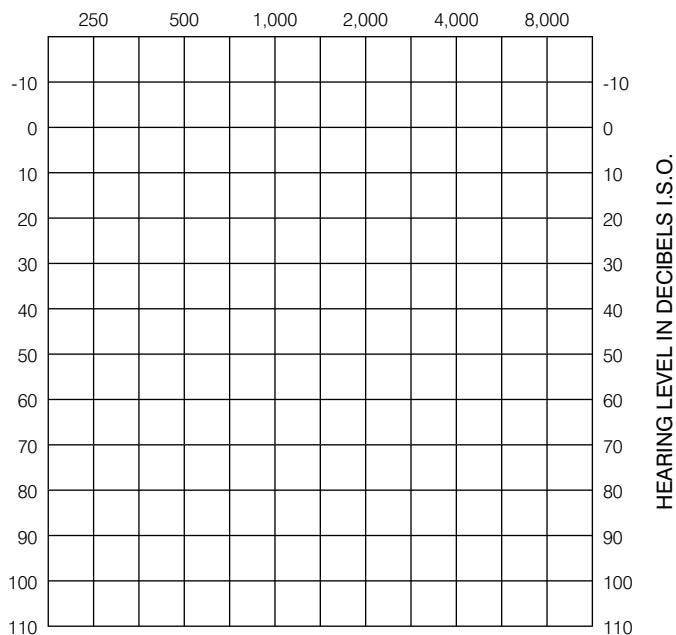
When placing orders with Salmat quote the following information:

Item no. 606301	Audiometry Report Form	CH5A
Item no. 606302	Audiometry History Form	CH5B

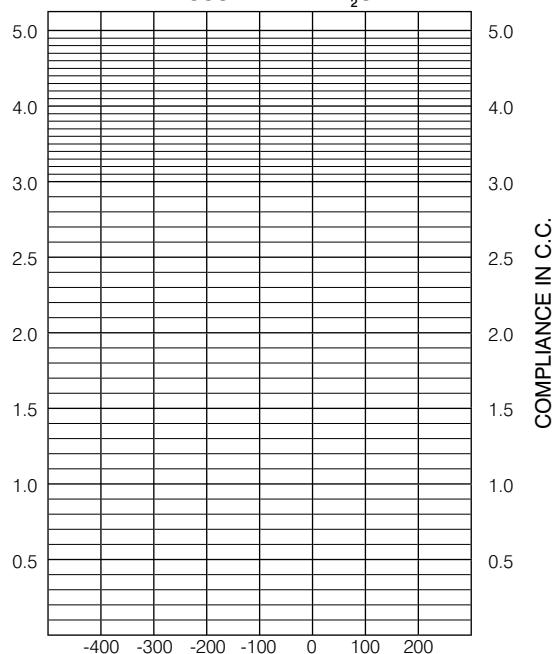
AUDIOMETRY REPORT FORM

Name:		M / F	Record No:	Centre:
Address:			P/Code:	Tel:
Pre/School:		Class:	DOB / /	Age:
Referral Source:	GP: SPECIALIST:	Assessment Date: / / Time:		
Presenting Problems (If new) See History form dated / / Since last assessment on / /				

AUDIOGRAM FREQUENCY IN HERTZ



TYMPANOGRAM PRESSURE IN mm H₂O



AIR CONDUCTION

UNMASKED: RIGHT LEFT

MASKED: RIGHT LEFT

BONE CONDUCTION

UNMASKED: RIGHT OR LEFT

MASKED: RIGHT LEFT

FREE FIELD

RIGHT EAR

MEP daPa
PV ml
COMP cc
GRAD %

LEFT EAR

MEP daPa
PV ml
COMP cc
GRAD %

IPSI/CONTRA

ACOUSTIC REFLEX THRESHOLD

Stimulus	.5KHz	1KHz	2KHz	4KHz
Probe R				
Probe L				

Hearing Assessment Results:

Otoscopy (Right) Normal / Other _____

Otoscopy (Left) Normal / Other _____

Tympanometry: _____

Audiogram: (Freefield Only) Age appropriate responses cannot rule out unilateral loss. _____

Action: Results and Explanations to: _____ Copy/s to: _____

No further Action at this time / Review on request. _____

Refer to: _____

Hearing Assessment conducted by (print) _____ Client / Carer agreed to Action Plan _____

Nurse Audiometrist

Student Nurse Audiometrist

Signature _____ Date: / /

SIGNATURE

AUDIOMETRY HISTORY FORM

Name:		M / F	Record No:	Centre:
Address:			P/Code:	Tel:
Pre/School:		Class:	DOB / /	Age:
Referral Source:	GP: SPECIALIST:	Assessment Date: / / Time:		
Presenting Problems (Reason for Referral)				

Child (Birth to 15 years)

Adult (15 years onwards)

Pregnancy: _____ wks Type of Delivery _____

NICU/SCN/Other _____

Newborn Hearing Screening Y / N Outcome PASS / REFER

Family History of Deafness Y / N _____

Inutero Infections? Y / N _____

Cranio-Facial Abnormalities Y / N Birth weight <1500gm Y / N

Ototoxic Medication > 7 days Y / N Apgar < 7 at 5 mins Y / N

Ventilation > 5 days Y / N Syndrome Y / N

Head Trauma Y / N Jaundice Y / N

Phototherapy Y / N

Other _____

Speech Development _____

General Health _____

Previous Ear Infections _____

Behaviour _____

Medication _____

Infectious Diseases (List) _____

Previous Hearing Assessment? Y / N Date: ____ / ____ / ____

Where? _____

Outcome (if known) _____

Previous ENT Consultation? Y / N Date: ____ / ____ / ____

Where? _____ Who? _____

Outcome (if known) _____

Other details not listed above eg. School Performance,
Parental concerns etc: _____

Family History of Deafness? Y / N

General Health _____

Medications: _____

Severe Head Injuries? Y / N Noise Exposure? Y / N

Type of Noise: _____

Length of Exposure _____ Hearing Protection then? Y / N

Hearing Protection now? Y / N

Previous Hearing Assessment? Y / N Date ____ / ____ / ____

Where? _____

Outcome (if known) _____

Previous ENT Consultation? Y / N Date ____ / ____ / ____

Where? _____ Who? _____

Outcome (if known) _____

Hearing Aid? Y / N Worn Y / N

Hearing problems noted:

TV	Y / N	Phone	Y / N	Meetings	Y / N
In a Car	Y / N	In Groups	Y / N	Generally	Y / N
Feel that People Mumble	Y / N	Smoker	Y / N		

Other Details not listed Above:

Presenting Symptoms:

Suspected Hearing Loss? Y / N Unilateral R / L Bilateral How Long? _____

Any of the Following?

Fullness	Y / N	Pain	Y / N	Discharge	Y / N	Dizziness	Y / N	Mouth Breather	Y / N
Excessive Headaches	Y / N	Nasal Congestion	Y / N	Asthma	Y / N	Allergies	Y / N	Snores	Y / N

(If Child) Can Blow Nose? Y / N Do loud noises hurt the ears? Y / N Regularly exposed to Cigarette Smoke Y / N

Any Tinnitus? Y / N Intermittent/Continuous Unilateral R/L – Bilateral How Long? _____

Other _____

History given by _____

I / Self / Parent / Carer consent to the results of this hearing assessment of _____ being provided to _____

Signature _____ Date: ____ / ____ / ____

History recorded by (print) _____ Client / Carer agreed to Action Plan _____

Nurse Audiometrist Student Nurse Audiometrist Signature _____ Date: ____ / ____ / ____