



AUDITORY FUNCTIONS SCREENING (AF)

Name _____ Date _____
 Address _____
 Phone _____ E-Mail _____

How is your hearing?

Subtest	Total Correct	Challenge	Profile	Strength
Pure Tone Sweep Frequency				
Right Ear				
Decibel = 20	1000	2000	4000	8000
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decibel = 25	1000	500	250	
		<input type="radio"/>	<input type="radio"/>	
	<input type="text"/>	0 - 5		6
		<input type="checkbox"/>		<input type="checkbox"/>
Left Ear				
Decibel = 20	1000	2000	4000	8000
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decibel = 25	1000	500	250	
		<input type="radio"/>	<input type="radio"/>	
	<input type="text"/>	0 - 5		6
		<input type="checkbox"/>		<input type="checkbox"/>

NOTES REGARDING REFERRALS

- If either total score falls into the challenge range, the participant should be retested in two weeks. Mark second screening responses with a ✓.
- If the second screening also shows a challenge in either the right ear or left ear, complete the Auditory Referral Form below.
- **Remember:** The 10 Decibel Rule
- **Remember:** Do not make a referral without rescreening first.

Remember the 10 Decibel Rule!

Fold and tear along dotted line.

PowerPath Auditory Functions Referral Form

Date ___/___/___

(Print name) _____ participated in an auditory screening.

Challenges were noted in the following areas:

Right Ear	<input type="checkbox"/> 1000 Hz	<input type="checkbox"/> 2000 Hz	<input type="checkbox"/> 4000 Hz	<input type="checkbox"/> 8000 Hz	<input type="checkbox"/> 500 Hz	<input type="checkbox"/> 250 Hz
Left Ear	<input type="checkbox"/> 1000 Hz	<input type="checkbox"/> 2000 Hz	<input type="checkbox"/> 4000 Hz	<input type="checkbox"/> 8000 Hz	<input type="checkbox"/> 500 Hz	<input type="checkbox"/> 250 Hz

If you have any questions about this screening, please contact:

Signed _____

