LAKES DISTRICT HEALTH BOARD

Ear Clinic Registration Form

Please read both sides.
Parent/caregiver to complete, sign and return to the school office or Ear Nurse.

Please Print the Child's Details			
Childs First Name:	Childs Last Name:		
Date of Birth:	Age:	Please circle: Male or Female	NHI:
Address:			
Telephone:	Ethnicity:		
School/Preschool:			
Parent/Caregivers Name:	Relationship with child (i.e. Mum/Koro):		
Name of Doctor:			
Any Allergies:			
What is your ear health concern? What would you like us to check?			
Previous Ear Health History			

Informed Consent – Ear Clinic

I am the Parent/Guardian of _____ (Childs name)

I consent to my child's ears being examined. ❑ **YES** ❑ **NO**

I consent to ear treatment as required until complete. ❑ **YES** ❑ **NO**

I consent to my child's results being shared with their doctor, relevant health professionals and teacher. ❑ **YES** ❑ **NO**

A report will be forwarded to you on any treatment carried out on your child. You will be advised if a further referral is needed.
Please note this is not a hearing test

Signature _____ Date _____
(Parent or legal guardian)

Information for Parent/Guardian

What Is Ear Examination?

- **Use** of a specialised "torch" (otoscope) to look inside the ear canal to view the eardrum.
- **Tympanometry** - a machine which measures how an eardrum moves indicating fluid in the middle ear.
- **Audiometry** – a machine which indicates the level of hearing in each ear.

What Is Ear Treatment?

Use of microscope and suction equipment to clear wax and/or mucous from the ear canal when:

- the ear has a discharge;
- the child has a failed tympanometry test and wax needs to be removed to examine the eardrum;
- a large amount of wax is blocking the ear canal.

OFFICE USE ONLY – Health History

This section is to be completed by the Ear Nurse Specialist/Public Health Nurse

CHILDS NHI: _____

ORL Specialist: _____ Surgery: _____ Date: _____

ORL Specialist: _____ Surgery: _____ Date: _____

Ear/Hearing Problems: _____

Birth: _____ Developmental: _____

Medical : _____ Hospitalisation: _____

Medication: _____ Referral Source: _____

_____

_____

_____

AUDIOMETRY INITIAL SCREEN DATE:					
Right Ear			**Left Ear**		
500Hz	30dB		500Hz	30dB	
1000Hz	40dB or 20dB		1000Hz	40dB or 20dB	
2000Hz	20dB		2000Hz	20dB	
4000Hz	20dB		4000Hz	20dB	
❑ Pass	❑ Fail		❑ Pass	❑ Fail	
RESCREEN DATE:					
Right Ear			**Left Ear**		
500Hz	30dB		500Hz	30dB	
1000Hz	40dB or 20dB		1000Hz	40dB or 20dB	
2000Hz	20dB		2000Hz	20dB	
4000Hz	20dB		4000Hz	20dB	
❑ Pass	❑ Fail		❑ Pass	❑ Fail	

Patient Name:

Date & Time:			Clinic:	

Right ear					Left ear				
Activity	Canal	Drum	Middle	Tymp	Activity	Canal	Drum	Middle	Tymp

Nurse Notes:

Date & Time:			Clinic:	

Right ear					Left ear				
Activity	Canal	Drum	Middle	Tymp	Activity	Canal	Drum	Middle	Tymp

Nurse Notes:

Patient Name:

Date & Time:			Clinic:	

Right ear					Left ear				
Activity	Canal	Drum	Middle	Tymp	Activity	Canal	Drum	Middle	Tymp

Nurse Notes:

Date & Time:			Clinic:	

Right ear					Left ear				
Activity	Canal	Drum	Middle	Tymp	Activity	Canal	Drum	Middle	Tymp

Nurse Notes: