Information Bulletin

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New State Forms for use by Audiometry Nurses in Community Based Hearing Services

Document Number IB2014_027

Publication date 13-May-2014

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

Summary The information bulletin provides advice regarding the availability of revised state forms for use by Audiometry Nursing services in Community Health settings.

Replaces Doc. No. Audiometry - New Forms for use by Community Nurses in NSW Health Hearing Clinics [PD2005_617]

Author Branch NSW Kids and Families

Branch contact NSW Kids and Families 9424 5991

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Affiliated Health Organisations, Community Health Centres, Public Hospitals

Audience All staff

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 13-May-2019

Policy Manual Not applicable

File No. 13/4063

Status Active

Director-General

INFORMATION BULLETIN

NEW STATE FORMS FOR USE BY AUDIOMETRY NURSES IN COMMUNITY BASED HEARING SERVICES

PURPOSE

To provide advice regarding the release of revised forms for use by Audiometry Nurses in community based hearing services.

KEY INFORMATION

NSW Kids and Families recently conducted a review of the Audiometry forms used by Nurse Audiometrists in NSW Health community health clinics.

This review was prompted by:

- The need to format all state forms to the current template, including the current NSW Health logo and unique barcodes to facilitate scanning to EMR
- The changed professional title of Audiometry Nurses (previously Nurse Audiometrists)
- A need to collected data regarding the Aboriginal and Torres Strait Islander origin of patients.

The resulting form is particularly suited to assessment of children.

It is understood that this form may not be suitable for the work of Audiometrists in other settings and with primarily adult consumers. Further development of forms by NSW Kids and Families is anticipated for all hearing services in the future.

The forms can be ordered from Fuji Xerox on ePOD.

- When placing orders with Salmat quote the following information: NH606301 - Audiometry Report (Book of 100) (in triplicate)
- NH606302 - Audiometry History (Book of 100) (in triplicate)

ATTACHMENTS

1. Audiometry History Form (NH606302 SMR070.000)
2. Audiometry Report Form (NH606301 SMR070.001)

NSW GOVERNMENT Health

Facility:

AUDIOMETRY HISTORY

SMR070000

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Pre/School:	Class:	Is the person of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander
Referral Source:	GP: SPECIALIST:	
Assessment Date: / / Time:		

Presenting Problems (Reason for Referral):

Child (Birth to 15 years)

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) _____

Adult (15 years onwards)

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 Client / Parent / Carer (Name) _____

Consent given by Client/Parent/Carer (Name) _____ (Signature) _____

for this assessment and results being provided to _____

Signature _____ Date: ____/____/____

History recorded by (print) _____ Signature _____

☐ Audiometry Nurse ☐ Student Audiometry Nurse

NH606302 - 250214

Original - Medical Record **Copy -** Parent/carer **Copy -** LMO/ENT specialist/school/other referring agent

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

AUDIOMETRY HISTORY

SMR070.000

NSW GOVERNMENT Health

Facility:

AUDIOMETRY HISTORY

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Pre/School: | Class:

Referral Source: | GP: SPECIALIST:

Assessment Date: / / Time:

Is the person of Aboriginal or Torres Strait Islander origin?

☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander
☐ Yes, both Aboriginal and Torres Strait Islander

Presenting Problems (Reason for Referral):

Child (Birth to 15 years)

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Infectious Diseases (List) _____

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

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Family History of Deafness? Y / N

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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 ____/____/____

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In a Car Y / N In Groups Y / N Generally Y / N

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Signature _____ Date: ____/____/____

History recorded by (print) _____ Signature _____

☐ Audiometry Nurse ☐ Student Audiometry Nurse

Original - Medical Record **Copy -** Parent/carer **Copy -** LMO/ENT specialist/school/other referring agent

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

AUDIOMETRY HISTORY

SMR070.000

NH606302 - 250214

NSW GOVERNMENT Health

Facility:

AUDIOMETRY REPORT

SMR070001

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

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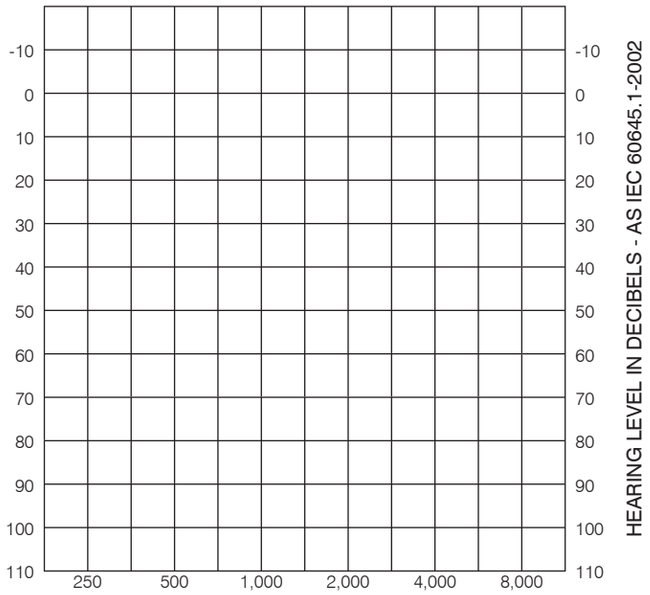
Referral Source:	GP: SPECIALIST:	
Assessment Date: / / Time:		

Presenting Problems (Reason for Referral):

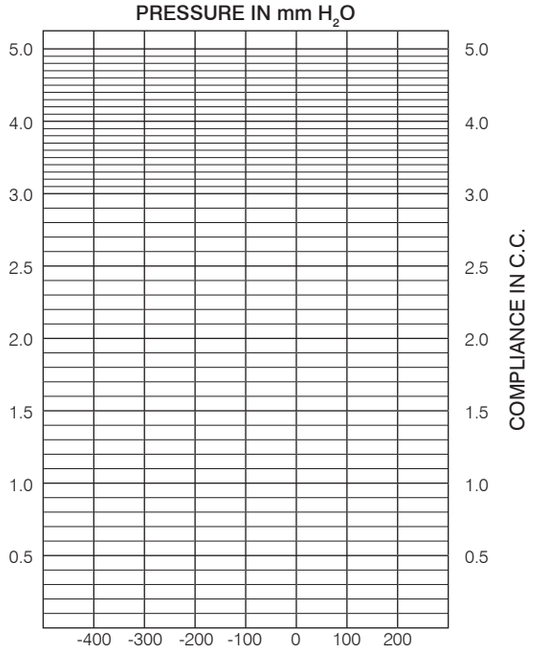
AUDIOGRAM

FREQUENCY IN HERTZ



TYMPANOGRAM

PRESSURE IN mm H_2O



AIR CONDUCTION
UNMASKED: RIGHT ○ LEFT X
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: _____

Consent given by Client/Parent/Carer (Name) _____ (Signature) _____
for this assessment and actions as above at date ___ /___ /___ Assessment conducted by (print) _____
Signature _____ ☐ Audiometry Nurse ☐ Student Audiometry Nurse

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

AUDIOMETRY REPORT
SMR070.001

NH606301 - 120314

Original - Medical Record **Copy -** Parent/carer **Copy -** LMO/ENT specialist/school/other referring agent

NSW GOVERNMENT Health

Facility:

AUDIOMETRY REPORT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

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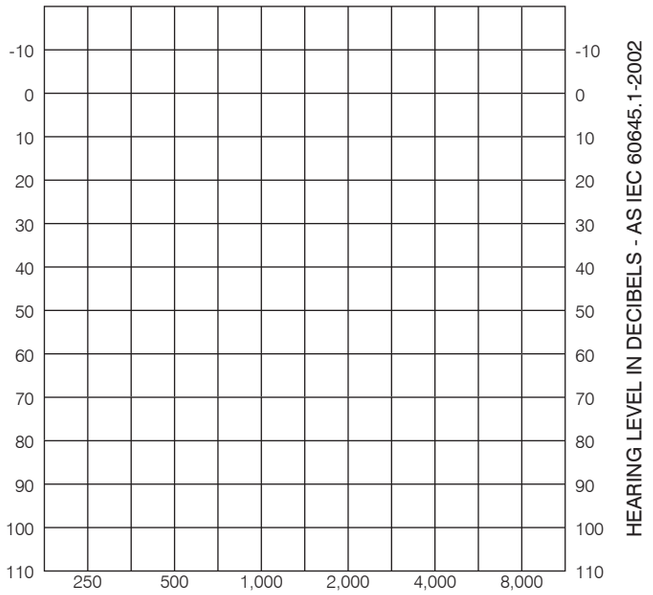
Referral Source:	GP: SPECIALIST:	
Assessment Date: / / Time:		

Presenting Problems (Reason for Referral):

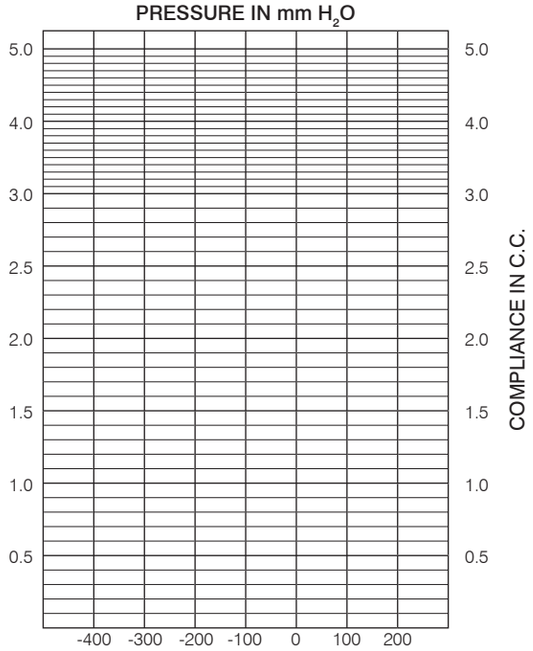
AUDIOGRAM

FREQUENCY IN HERTZ



TYMPANOGRAM

PRESSURE IN mm H_2O



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UNMASKED: RIGHT ○ LEFT X
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		%

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AUDIOMETRY REPORT

SMR070.001

NH606301 - 260214