

TRANSFER REPORT : Infants and children

Referring program:

Audiologist: Date:

Referral to Cochlear Implant Program:

Recipient Particulars

Surname		First name	
Date of birth		I.D No	
Name of mother		Name of father	
Residential address			
Postal address			
Home Tel	Cell	Business	Email

Case History Information

	Right ear	Left ear
Age at onset of hearing loss		
Date of diagnosis of hearing loss		
Duration of deafness before implantation		
Use of hearing aids		
Pre-operative hearing test results		

Warble Tone Freefield Thresholds

Date:

	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									

Speech and Language development

Implant History									
	Right					Left			
Date of initial surgery									
Implanting Surgeon									
Audiologist									
Hospital									
Implant Model									
Implant Serial Number									
Comment									
Sound Processor History									
	Right					Left			
Initial stimulation date									
Current Processor Model									
Serial number									
Magnet strength									
Coil									
Cable									
Remote S/N									
Mapping									
	Right					Left			
Speech coding strategy									
Mode									
Rate									
Maxima									
Pulse width									
Pre-processing									
Electrodes deactivated									
Comment									
Warble Tone Freefield Thresholds									
Date:									
	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									
Speech Perception Scores									
Date:									
Test Items	Presentation Recorded/Live		Presentation Level		Right score	Left Score	Bimodal/Bilateral		

Recommendations

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