

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			
Contact person	Cell	Business / Home	Email

Case History Information

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

Warble Tone Freefield Thresholds (pre-implant)

Date:

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

Speech and Language development (include most recent report)

Left									
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Speech Perception Scores									
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Date:									
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Test Items	Presentation Recorded/Live	Presentation Level	Right score	Left Score	Bimodal/Bilateral

Recommendations									
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