State of Illinois
Illinois Department of Public Health

AUDIOGRAM

Date _____

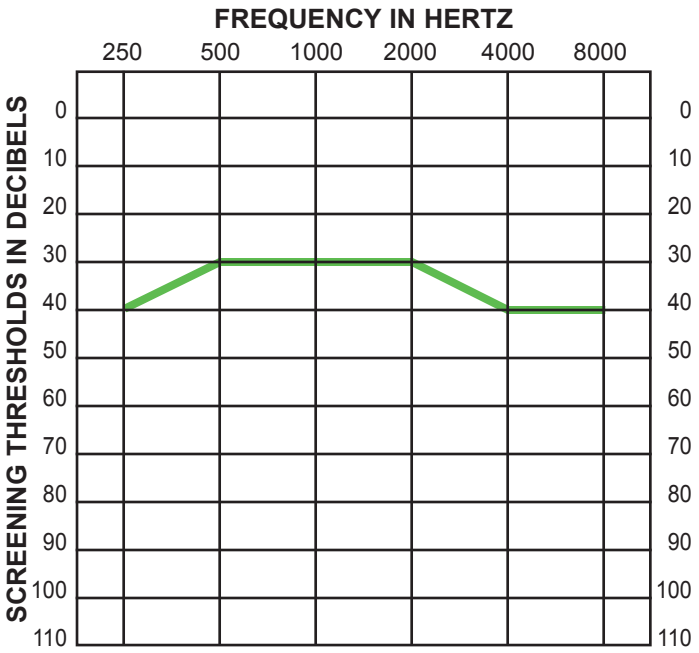
Test Number _____

Name _____ Birth date _____ Sex _____ Grade _____
(last) (first) (initial) (month) / (day) / (year)

Parent/Guardian _____ Phone (_____) _____
(last) (first)

Address _____ County _____
(number/street) (city) (ZIP code)

Testing location _____ Testing agency _____



Tester _____

Audiometer and Serial number _____

Audiogram Code
(Air Conduction)

Right ear – 0 (*red*) Left ear – X (*blue*)

NOTE: This screening audiogram is plotted on ISO or ANSI reference levels.

Pure tone average of the speech frequencies
(500 - 1000 - 2000 Hz)

Right _____dB Left _____dB

Test environment *(check one)* ❑ Satisfactory ❑ Unsatisfactory

Responses *(check one)* ❑ Reliable ❑ Unreliable

Comments _____

For referral purposes – CHECK AND SIGN WHERE APPROPRIATE

Minimum criteria for referral (medical/educational)

❑ 1. Any two **speech** frequencies (500 - 1000 - 2000 Hz) in the same ear that fall on or below the solid green line, OR

❑ 2. Any two consecutive frequencies ([250-500] [2000 - 4000] [4000 - 8000] Hz) In the same ear that fall on or below the solid green line.

❑ Referred on _____
(date)

Signature _____ Title _____