

# Cleft Collective Speech and Language Study – Hearing Record

Cleft Collective - ID

Please record the results of all hearing tests up to date

**Soundfield**  
Measurement

Date of test	Type of test eg. VRA/ABR	Soundfield <input type="checkbox"/> or RIGHT ear <input type="checkbox"/> – please tick Please specify level in dBHL/dBeHL				Reliable? yes/no	Right tympanometry – please tick						
		0.5 KHz	1	2	4		peaked	flat	P	G	U		
						Yes/no							
						Yes/no							
						Yes/no							
						Yes/no							
						Yes/no							

**Or Right Ear**  
(If individual ears measured)

**Left Ear**  
(if individual ears measured)

Date of test	Type of test eg. VRA/ABR	LEFT ear Please specify level in dBHL/dBeHL				Reliable? yes/no	Left tympanometry – please tick						
		0.5 KHz	1 KHz	2 KHz	4 KHz		peaked	flat	P	G	U		
						Yes/no							
						Yes/no							
						Yes/no							
						Yes/no							
						Yes/no							

Any additional difficulties?

YES / NO

Sensorineural component?

YES / NO

Any grommet insertions since birth?

YES / NO

Aids fitted since birth?

YES / NO

Grommet insertions within last 12 months?

YES / NO

Aids fitted within last 12 months?

YES / NO

<b>P</b> = perforation
<b>G</b> = grommets
<b>U</b> = unclassified