



# CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT

190 E. Michigan Avenue Phone: 269-969-6370  
Battle Creek, Michigan 49014 Fax: 269-969-6470  
www.calhouncountymi.gov/publichealth

"Working to enhance our community's total well-being"

\_\_\_\_\_  
Date

To Parent/Guardian of:

Dear Parent/Guardian,

Hearing screening is provided at school by the Calhoun County Public Health Department as required by the Michigan Department of Health and Human Services. Two screenings are provided 3-4 weeks apart. Your child was screened twice and did not respond at normal hearing levels.

Abnormal hearing results could indicate a need for medical attention. The results are enclosed.

The goal of the hearing program is to locate children with potential hearing concerns and assist them to find help. We recommend that your child have an exam with his/her doctor as soon as possible. Please take the enclosed report and this letter for the doctor's office to complete. The form should be faxed or mailed to the health department.

If your child does not have medical insurance, programs may be available to help. Learn more by visiting [www.michigan.gov/mibridges](http://www.michigan.gov/mibridges) or calling the Michigan Health Care Helpline at 1-855-789-5610.

Any questions or concerns may be directed to our Hearing and Vision Technicians:

Heidi Fast-Hackworth: 269-969-6389, [hfast@calhouncountymi.gov](mailto:hfast@calhouncountymi.gov)

Christy Benson: 269-969-6361, [cbenson@calhouncountymi.gov](mailto:cbenson@calhouncountymi.gov)

**Hearing Report:**  
**Fax No. 269-969-6488**

**Diagnosis:**

- \_\_\_\_\_ Eustachian Tube Dysfunction
- \_\_\_\_\_ Otitis Media
- \_\_\_\_\_ Cerumen Impaction
- \_\_\_\_\_ TM Perforation
- \_\_\_\_\_ Cholesteatoma
- \_\_\_\_\_ Sensorineural Hearing Loss
- \_\_\_\_\_ Mixed Hearing
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Normal Exam

**Treatment:**

- \_\_\_\_\_ Medication
- \_\_\_\_\_ Tubes
- \_\_\_\_\_ Cerumen Removal
- \_\_\_\_\_ Surgical
- \_\_\_\_\_ Hearing Aids
- \_\_\_\_\_ No treatment at this time

**Further Treatment:**

- \_\_\_\_\_ Follow-up Medical Exam
- \_\_\_\_\_ Repeat Hearing Exam

Physician: \_\_\_\_\_ Date \_\_\_\_\_  
(please print or stamp)