State of Illinois
Illinois Department of Public Health

AUDIOGRAM

Date _____

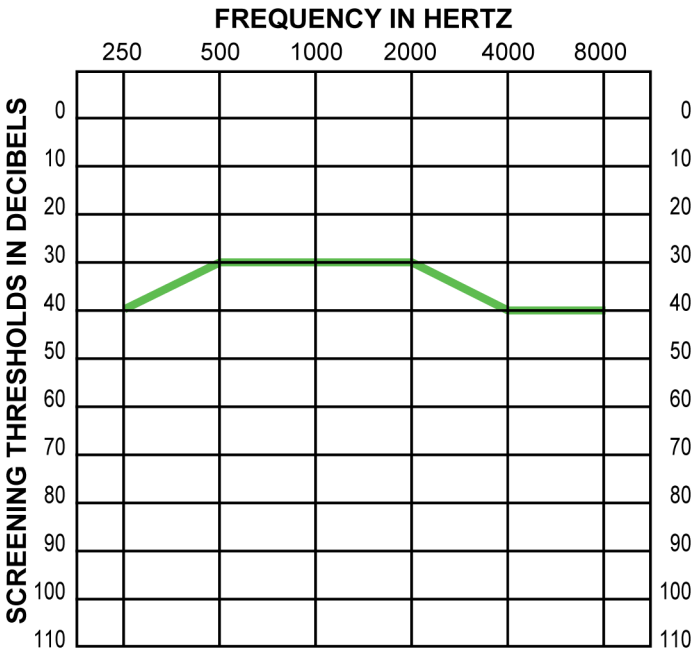
Test Number _____

Name _____ _____ _____ Birth Date _____ Sex ___ Grade _____
(last) (first) (m.i.) (m/d/yyyy)

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

Address _____ _____ _____ County Select 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 _____

Signature _____ Title _____

Printed by Authority of the State of Illinois 5/26 IOCI 26-1550