တၢ်နၢ်ဟူ တၢ်ဆှၢခီဆူညါ လံာ်ပရၢ

ဖိသၣ်အမံၤ- ______________________________ နံၤအိၣ်ဖျဲၣ်- ______________________

မိၢ်ပၢ်/ပှၤကွၢ်ထွဲတၢ်သးဘိတဖၣ်ဧၢ:

ပကိုဟ့ၣ်လီၤဝဲ တၢ်နၢ်ဟူတၢ်မၤကွၢ် ခီဖျိ စူးကါ မံၣ်နံၣ်စိထၣ်ဆူၣ်ချ့ဝဲၤကျိၤ အတၢ်နဲၣ်ကျဲတဖၣ်လီၤ. နဖိအတၢ်နၢ်ဟူတၢ်နၣ် တၢ်မၤကွၢ်အီၤဖဲ _____/______/____ ဒီး ဘၣ်တၢ်မၤကဒါကွ့ၤအီၤဖဲ _____/______/____နၣ်လီၤ.

- နဖိတခီဆၢထိၣ် တၢ်အကလုၢ်ခဲလၢာ် လၢအတၢ်နၢ်ဟူတၢ်မၤကွၢ်အပူၤဘၣ်. ဝံသးစူၤ ကွၢ်သဃဲၤဘၣ် လံာ်တီၤဖျါလၢလာ်တက့ၢ်.

Pure Tone Audiometry – Right Ear	Initial Screen	Rescreen
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER
Pure Tone Audiometry – Left Ear	**Initial Screen**	**Rescreen**
500 Hz, 25 dB	PASS/REFER	PASS/REFER
1000 Hz, 20 dB	PASS/REFER	PASS/REFER
2000 Hz, 20 dB	PASS/REFER	PASS/REFER
4000 Hz, 20 dB	PASS/REFER	PASS/REFER
6000 Hz, 20 dB (ages 11 and up)	PASS/REFER	PASS/REFER

- တၢ်အစၢတဖၣ်အံၤ အခီပညီမ့ၢ်ဝဲ နဖိဘၣ်သ့ၣ်သ့ၣ်ကအိၣ်ဒီး တၢ်နၢ်ဟူအတၢ်ဂ့ၢ်ကီနၣ်လီၤ.
- လၢကသမံသမိးမၤကွၢ်အတၢ်နၢ်ဟူအဂီၢ်, ဝံသးစူၤ လဲၤကိးဘၣ်နဖိအံၤဆူ နကသံၣ်ဒၢး ဒီး/မ့တမ့ၢ် တၢ်နၢ်ဟူဂ့ၢ်ဝီပီညါကသံၣ်သရၣ် (တၢ်နၢ်ဟူဂ့ၢ်ဝီပှၤသ့ပှၤဘၣ်) အအိၣ်တက့ၢ်.
- နဖိအံၤ မ့ၢ်ဒိးန့ၢ်ဘၣ်တ့ၢ်လံဝဲ တၢ်အံးထွဲကွၢ်ထွဲ လၢတၢ်နၢ်ဟူတၢ်အဂီၢ် မ့တမ့ၢ် နမ့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤ လၢကဃုထံၣ် ပှၤဟ့ၣ်ဆူၣ်ချ့တၢ်အံးထွဲကွၢ်ထွဲတဂၤနၣ်, ဝံသးစူၤတဲဘၣ် ကိုအနၢးစ်အံၤတက့ၢ်.
- ဝံသးစူၤ ဟ့ၣ်လီၤဘၣ် လံာ်ပရၢအံၤ ဃုာ်ဒီး ကိုတၢ်နၢ်ဟူတၢ်အစၢတဖၣ် ဆူတၢ်ဆါဟံၣ်အံၤ ဒီး/မ့တမ့ၢ် ဆူတၢ်နၢ်ဟူဂ့ၢ်ဝီပီညါကသံၣ်သရၣ် လၢအကမၤ တၢ်နၢ်ဟူတၢ်သမံသမိးအံၤ တက့ၢ်.
- တၢ်သံကွၢ်မ့ၢ်အိၣ်ဒီးနၤ မ့တမ့ၢ် နမ့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤ လၢကဘျးစဲလိာ်သးဒီး ကသံၣ်ဒၢးတဖျၢၣ်နၣ်, ဝံသးစူၤ ဆဲးကျိးဘၣ်ပှၤတက့ၢ်.

▪ ____

Health Care Provider, please complete this form.

Child's Name: ______________________________ Date of Birth: __________________

School Name: ______________________________

Provider comments:

I have examined this child on______/______/______ and find the following:

MEDICAL:

- ☐ Hearing (circle): PASS or REFER
- ☐ Medically treatable
- ☐ Not medically treatable
- ☐ Outer Ear
- ☐ Middle Ear
- ☐ Inner Ear
- ☐ Refer to Audiology

Further Comments: ____________________

____

____

Recommendations to support learning in the school environment: _________________________

____

____

AUDIOLOGICAL:

- ☐ Normal Hearing
- ☐ Conductive Hearing Loss
- ☐ Mixed Hearing Loss
- ☐ Sensorineural Hearing Loss
- ☐ Refer to Physician
- ☐ Amplification Evaluation

Further Comments: ______________________

____

____

Recommendations to support learning in the school environment: _________________________

____

____

Child should return for follow up examination on ________________________________

Provider Name/Title: ____

Contact Information ____

Schools nurse or health staff fill out this section below before sending home.

Please have the parent return this form to the school or you can return this to:

School Nurse Name: ____

Phone: ____________________________

Address :____

____

Email:____

This templated form was developed by MDH for use in schools.

မံၣ်နံၣ်စိထၣ်ဆူၣ်ချ့ဝဲၤကျိၤ (Minnesota Department of Health)
ဖိသၣ်ဒီးပှၤလိၣ်ဘိ တၢ်သမံသမိးတဖၣ် (Child and Teen Checkups)
651-201-3650
health.childteencheckups@state.mn.us
www.health.state.mn.us

12/2023

လၢကမၤန့ၢ် လံာ်တကွိၣ်ဒိအံၤ လၢကွၢ်ဂီၤဒိအဂုၤအဂၤတခါအဂီၢ်, ကိးလီတဲစိ ဆူ- 651-201-3650.