Audiology Department
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St. Petersburg, FL 33701
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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL

Johns Hopkins All Children's Hospital Cochlear Implant Program
Supplemental Case History

Today's Date: _____

Patient Name: _____ Male / Female MR#: _____

Date of Birth: _____ Age: _____ Caregiver: _____

Address: _____

City, State & Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Primary Preferred Contact: ☐ Phone ☐ Email

Primary Language spoken in the home: _____ Interpreter Required: Yes No

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Is your child followed by a JHACH Audiologist? Yes No

If no, please provide this information on the last page of this form.

***Please provide a copy of the most recent hearing test(s) for audiologist to review before an appointment will be scheduled, if not followed at a JHACH facility.*

Does your child currently wear hearing aids? Yes No Please circle: Right ear Left ear Both ears

Does your child receive therapy that emphasizes hearing and spoken language development? Yes No Don't know

***Please provide a copy of the most recent speech and language treatment report for audiologist to review before an appointment will be scheduled, if not followed at a JHACH facility.*

Does your child have any other conditions other than hearing loss such as traumatic brain injury, cerebral palsy, brain tumor, seizures, vision loss, diagnosis of autism, diagnosis of Asperger syndrome, ADD/ADHD and/or any psychological/psychiatric disorders?

Do they receive Occupational, Physical, or ABA therapy?

Has the child ever been evaluated by a psychologist, psychiatrist, neurologist and/or developmental-behavioral pediatrician?

If yes to any of the above, please describe:

_____

_____

_____

_____

***Please provide copies of physician reports relative to any conditions noted above*

HEARING/AUDIOLOGICAL/LANGUAGE HISTORY:

At what age was your child diagnosed with a severe-profound sensorineural hearing loss? _____

Did your child pass his/her newborn hearing screening shortly after birth? Yes No

If yes, at what age was concern for hearing loss noted? _____

Who first noticed the hearing loss? _____

Did your child's hearing worsen over time? Yes No

Is there a known cause of hearing loss? _____

Who made the diagnosis? (name/facility): _____

What is the primary communication mode of your child (if appropriate)?

□ Oral communication (spoken language)
□ American Sign Language only
□ Total communication (spoken language and sign)
□ Cued speech

What is the communication mode of the parents/family?

□ Oral communication (spoken language)
□ American Sign Language only
□ Total communication (spoken language and sign)
□ Cued speech

If your child uses sign language as their primary mode of communication, do all members of the household sign?

Yes No

If no, why not? _____

_____

_____

Is there more than one spoken language in the house? Yes No

If yes, which language(s)? _____

If your child is under 3 years of age, are you receiving Early Intervention Services? Yes No

If yes, with whom and how often? _____

_____

_____

EDUCATIONAL HISTORY:

If your child does not attend school, please use "N/A."

Age of child when first started school: _____ Current school name: _____

Current grade placement: _____ Approximate number of students in class: _____

Type of classroom child is enrolled in: (Check all that apply):

□ Mainstream □ Self-contained □ Full day □ Half day □ Other (please explain) :

_____

Has your child ever received any remedial help or therapy services through the school system? (Check all that apply):

□ Aural rehabilitation/Auditory training □ Speech/Language therapy □ Remedial reading
□ Physical therapy □ Occupational therapy □ Sensory integration therapy
□ Other (please explain): _____

Is an interpreter used in the classroom? Yes No

If yes, what type? _____

Is an auditory trainer/FM system used in the classroom? Yes No

If yes, please provide brand/model (if known): _____

During the school hours, are the hearing aids removed? Yes No

If yes, when and why? _____

Rate the child's current academic performance: Upper 25% Middle 50% Lower 25%

Any additional comments you would like us to know about your child or family? _____

_____

_____

_____

PROVIDER INFORMATION:

Primary Care Physician/Pediatrician: _____
Phone: _____
Mailing/Email Address: _____
_____

ENT Physician (first and last name): _____
Phone: _____
Mailing/Email Address: _____
_____

Audiologist (first and last name): _____

Phone: _____

Mailing/Email Address: _____

_____

Speech/Language therapist (first and last name): _____

Phone: _____

Mailing/Email Address: _____

_____

Please have all the requested records forwarded to Johns Hopkins All Children's Hospital PRIOR to scheduling your child's appointment.

Records may be sent to:

Shelly Ash, MS, CCC-A
Cochlear Implant Coordinator/Audiologist
880 6th Street South Suite 110
St Petersburg, FL 33701
727 767 8989 (office)
727 767 8998 (fax)