**Ear checks questionnaire for children and young people attending special residential schools**

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| **Purpose:**    The purpose of this questionnaire is to identify any reasonable adjustments the child or young person may need in preparation for their ear check. The information will also support onward referral where needed.    **Part 1** of this questionnaire identifies any reasonable adjustments which are needed for a child or young person to access an ear check.    **Part 2** of this questionnaire identifies the child or young person’s response to sounds in daily life and supports onward referral where there is concern about ear or hearing problems. |
| **Instructions for Use:**    The questionnaire should be completed by the person carrying out the ear check, with the help of information provided by the parent/carer or a member of staff who knows the child or young person well. This process should take approximately 10-15 minutes to complete. Both parts of the questionnaire should be completed before an ear check is carried out. This information collected should accompany any referral made to support ongoing care.    If the young person is Gillick competent,16 years of age or older, or is able to participate in answering questions, they should be included in answering the questionnaire. |

**Part 1 – Preparing for an ear check**

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| **Child or young person’s details** | | | |
| **Name** | Click here to enter text. | | |
| **Date of birth** | Click here to enter a date. | **NHS Number** | Click here to enter text. |
| **School** | Click here to enter text. | | |
| **Postcode** | Click here to enter text. | **Gender** | Choose an item. |
| **Parent/**  **Carer Address** | Click here to enter text. | | |

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| **Diagnoses:**  Please specify known clinical diagnoses or impairment the service should be aware of to plan for the child or young person’s ear check. |
| Click here to enter text. |
| **Communication:**  Please specify method(s) of communication used by the child or young person and any specific communication support needed. |
| Click here to enter text. |
| **Hearing:**  Please specify any concern(s) about undiagnosed ear or hearing problems |
| Click here to enter text. |
| **Thinking about the needs of this child or young person** |
| **Q1. What considerations might the child or young person need when planning the hearing check?** |
| Please specify if there is a preferred place at school where the child or young person feels most relaxed and which may support receiving the ear check (e.g.sensory room)? |
| Click here to enter text. |
| Please specify if there is a preferred time of day when the child or young person may be most receptive to an ear check (e.g.during a therapy session)? |
| Click here to enter text. |
| Please specify preferred lighting e.g., dimmed, bright, coloured, natural light |
| Click here to enter text. |
| Please specify if there are aromas/smells which should be taken into consideration |
| Click here to enter text. |
| Please specify any other adaptations to consider to support the child or young person |
| Click here to enter text. |
| **Q2. The child or young person should be accompanied by someone well known to them during their ear check. Who should be present (eg. school staff member and/or parent)?** |
| Name of person:  Relationship to the child or young person: |
| **Q3. Would the parent/carer like to be present during the ear check** |
| Click here to enter text. |
| **Q4. Which of the following would be the best way to prepare the child or young person for their ear check? (Please tick all that apply)** |
| Watch process via a video  Social story, using the listening method used by the child/ young person  ​☐​  Familiarisation with equipment ​  Role play  Familiarisation incorporated into a favourite activity / game  Play audio clip which is the sound heard during the test)  Ear massage  Other (please specify)  No techniques required ​ |
| **Q5. The ear check requires a child or young person to be still and quiet for a short period of time (up to 1 minute). What would best help this?** |
| **Position**    Sitting down ​  Standing up  Lying down  Other (e.g., positioned on sensory ball) (please specify) ​  **Comfort Objects**  Please specify any comfort objects to accompany child or young person during test ​ |
| **Q6. How will the child or young person show or say they are ready and willing to have an ear check?** |
| Click here to enter text. |
| **Q7.  How will the child or young person show or say that they are not willing to continue with the ear check?** |
| Click here to enter text. |
| **Q9.   Some children or young people are challenged by certain characteristics of people and places, for example, hair of a certain colour, direct eye-contact, beards, perfume, glasses etc.** **Please give details of any known characteristics that would present a challenge:** |
| Click here to enter text. |
| **Q10. As well as hearing, it is important to monitor a child or young person’s ear health. Issues with ear health can include wax build-up, infection, or ‘glue ear’ (where the middle ear is filled with fluid).** **Is the child or young person prone to any of the following (please tick all that apply)?** |
| Wax build up ​  Infection ​  Glue ear   ​  Recurring colds ​  Other (please specify) ​ |

**Part 1 of the questionnaire completed by:**

|  |  |
| --- | --- |
| **Name** | Click here to enter text. |
| **Your relationship to the child/young person** | Click here to enter text. |
| **Date** | Click here to enter text. |

**Part 2: Observations of everyday hearing and listening**

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| **Part 2 of the questionnaire gathers information about the child or young person’s hearing and listening to support onward referral to audiology services, where appropriate.** |
| Before you start part 2, please rate your level of concern about the child or young person’s hearing on a scale of 1 to 5 (where 1 represents ‘Not at all concerned” and 5 represents ‘Extremely concerned’). |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  ​ | 2 ​ | 3 ​ | 4 ​ | 5 ​ |
| Not at all concerned | Slightly concerned | Somewhat concerned | Moderately concerned | Extremely concerned |

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| **Q1a.Please complete the table below regarding the child/young person’s response to environmental sounds. Does the child or young person respond to the following sounds?** |

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| --- | --- | --- |
| **Type of sound** | **Yes/No/Not observed** | **Nature of Response** |
| Dog barking |  |  |
| Rainfall |  |  |
| Traffic/car noise |  |  |
| Microwave |  |  |
| Fire alarm |  |  |
| Washing machine |  |  |
| Sudden noise |  |  |
| Other familiar sounds e.g TV. |  |  |

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| Examples of reactions to sounds you may notice:    Turning to sound source  - Stopping activity                                   - Hitting objects and deriving pleasure from sound  - Stopping crying                                    - Vocalisation  - Change in breathing                             - Facial grimace  - Crying at sudden noise                        - Stopping vocalising  - Rocking                                                - Changes in vocalisation  - Banging                                                - Startling  - Interest in sound source                       - Joining in singing  - Eye widening or blinking                      - Reacting to sound stopping  - Attempting imitation of sound    (Modified from The British Association of Teachers of the Deaf (BATOD), Audiology guidelines for the assessment of children with special needs. Updated 2020 Appendix D ) |

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| **Q1b. After answering the previous question about environmental sounds, please indicate below how concerned you are about this child or young person’s response to environmental sounds on a scale of 1 to 5 (where 1 represents ‘Not at all concerned’ and 5 represents ‘Extremely concerned’).** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  ​ | 2 ​ | 3 ​ | 4 ​ | 5 ​ |
| Not at all concerned | Slightly concerned | Somewhat concerned | Moderately concerned | Extremely concerned |

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| **Q2a. Please complete the table below regarding the child or young person’s response to different kinds of voice.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Speaker** | **Voice level** | **Yes/No/**  **Not observed** | **Nature of the response** |
| Female | Whisper |  |  |
| Conversation |  |  |
| Raised |  |  |
| Male | Whisper |  |  |
| Conversation |  |  |
| Raised |  |  |

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| Examples of reactions when voice is heard:  -Turning to the voice  - Stops activity  - Stops crying  - Change in breathing  - Stopping vocalising  - Crying at sudden noise  - Rocking  - Startling  - Banging  - Joining in singing  - Eye widening or blinking  - Reacting to sound stopping  - Interest in sound source  - Attempting imitation of sound |

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| **Q2b. After answering the previous question, how concerned are you about the child or young person’s response to voice on a scale of 1 to 5 (where 1 represents ‘Not at all concerned’ and 5 represents ‘Extremely concerned’?** |

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| --- | --- | --- | --- | --- |
| 1  ​ | 2 ​ | 3 ​ | 4 ​ | 5 ​ |
| Not at all concerned | Slightly concerned | Somewhat concerned | Moderately concerned | Extremely concerned |

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| **Q3a. Does this child or young person react to any music?**  Your answers to this question will help to provide a more complete listening profile for this student. |
| Yes   ​  No    ​  Don’t know  ​ |
| **If yes, what type of music do they react to?** |
| Click here to enter text. |
| **Please indicate how they react to the music** |
| Click here to enter text. |

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| **Q3b.  After answering the previous question, how concerned are you about this child or young person’s response to music on a scale of 1 to 5 (where 1 represents ‘Not at all concerned’ and 5 represents ‘extremely concerned’?** |

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| --- | --- | --- | --- | --- |
| 1  ​ | 2 ​ | 3 ​ | 4 ​ | 5 ​ |
| Not at all concerned | Slightly concerned | Somewhat concerned | Moderately concerned | Extremely concerned |

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| **Q4a. If the child or young person shows self-stimulating behaviour, does the presence of sound change this behaviour?** |
| Yes   ​  No    ​ |
| **Q4b. If Yes, please give examples of sound that causes the change in behaviour.** |
| Click here to enter text. |
| **Q4c**. **If the presence of sound changes this behaviour, does it lead to?** |
| Please tick the appropriate option.     * more self-stimulating behaviour                ​ * less self-stimulating behaviour ​ * different self-stimulating behaviour​ |
| **Q5. Does the child or young person use ear-defenders?** |
| Yes   ​  No    ​  Don’t know  ​  If yes, how long does the child or young person use them each day on average (in hours)?  Click here to enter text. |
| **Q6. Does the child or young person engage in activities involving response to sound**  **e.g. beating a drum, singing, clapping in time to music** |
| Yes   ​  No    ​  Don’t know  If yes, please provide an example:  Click here to enter text. |
| **Q7. Finally, having completed the assessment on the range of sounds/noises eg TV, voices and music for this child or young person, please can you rate your concern about their hearing on the scale of 1 to 5 (where 1 represents ‘Not at all concerned’ and 5 represents ‘Extremely concerned’)?** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  ​ | 2 ​ | 3 ​ | 4 ​ | 5 ​ |
| Not at all concerned | Slightly concerned | Somewhat concerned | Moderately concerned | Extremely concerned |

**For the person conducting the ear check:**

* If you are concerned about this child’s hearing, please request an onward referral

to audiology (please follow local pathway)

* If you are concerned about the child or young person’s ear health, please refer to the

GP (please follow local pathway)

**Person Conducting the Ear Check:**

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| **Name** | Click here to enter text. |
| **Role** | Click here to enter text. |
| **Date** | Click here to enter text. |
| **Referral made (if applicable**) | Click here to enter text. |