

Pediatric Hearing Health Care Survey

Please mail or fax your survey to:

New Jersey Early Hearing Detection and Intervention Program (EHDI)
New Jersey Department of Health and Senior Services
PO Box 364
Trenton, New Jersey 08625-0364
FAX: 609-633-7820

**To make updates to information already published, please complete the
LAST PAGE of this survey and mail or fax to the EHDI Program.**

If you do not wish to have information about your facility made available to parents and health care providers, you may complete and return pages 1 and 2 only.

If you have any questions about completing this survey, please contact the Early Hearing Detection and Intervention program at 609-292-5676.

Please type or print clearly...

Section 1 – Contact Information

1.1 Name of person completing survey: _____

1.2 Phone number of person completing survey: _____

1.3 E-mail address of person completing survey: _____

Section 2 – Facility Information

2.1 Facility Name: _____

Business Address (in the event your facility has more than one site, complete a separate survey for each site)

2.2 Street address: _____

2.3 City: _____ 2.4 State: _____ 2.5 Zip: _____

2.6 County: _____

2.7 Telephone (Voice): _____

2.8 Telephone (TTY): _____

2.9 Fax: _____

2.10 Website: _____

2.11 Facility e-mail address(es): _____

2.12 Staff (include preferred designation, e.g., M.A., M.S., FAAA, CCC-A, BC-HIS, Au.D., Ph.D., etc.):

First Name	Last Name	Degree/Designation	E-mail address	✓

Please place a check mark (✓) next to any of the e-mail address(es) listed above that you would like to have included in your facility listing (which would make it available to both professionals and interested consumers).

2.16 Does your facility provide any of these services for **children**:

Audiologic services	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
Audiologic and hearing aid services	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid services only	<input type="checkbox"/>	<input type="checkbox"/>

Section 3 – Screening/Audiologic Evaluation Procedures

Indicate all procedures *currently available* at your office for **children**. Please place a check mark (✓) under the heading that applies (No; Yes, but over age 3 only; Yes, any age):

		No	Yes, but > age 3 only	Yes, any age
<u>OTOACOUSTIC EMISSION (OAE) SCREENING:</u>				
3.1	Distortion Product Otoacoustic Emissions (DPOAE)			
3.2	Transient Otoacoustic Emissions (TEOAE)			

AUDITORY BRAINSTEM RESPONSE (ABR) SCREENING/EVALUATION:

3.3	Diagnostic ABR Evaluation:			
3.4	ABR threshold measurement with click stimuli			
3.5	ABR threshold measurement with frequency specific tone bursts			
3.6	ABR threshold measurement via <u>bone</u> conduction stimuli			
3.7	ABR conscious sedation policy with medical monitoring			
3.8	Natural sleep ABR			
3.9	Operating Room ABR			
3.10	Other: _____			
3.11	ABR Screening			
3.12	Auditory Steady State Response (ASSR)			

IMMITTANCE TESTING:

3.13	Tympanometry			
3.14	Tympanometry with high frequency probe tone (for children < 6 months). _____ Hz			
3.15	Acoustic reflex testing			

BEHAVIORAL AUDIOLOGIC ASSESSMENT:

3.16	Visual Reinforcement Audiometry in soundfield			
3.17	Visual Reinforcement Audiometry utilizing insert earphones			
3.18	Conditioned Orienting Response Audiometry in soundfield			
3.19	Conditioned Orienting Response utilizing insert earphones			
3.20	Play Audiometry in soundfield			
3.21	Play Audiometry utilizing insert earphones			
3.22	Pure tone testing			
3.23	Speech audiometry			
3.24	Other: _____			

Section 4 – Cochlear Implant Services

4.1 Does your facility provide cochlear implant services for **children**?

- NO** If no, SKIP to Section 5, below
 YES

If yes, for what age range do you provide CI services: _____

Indicate which of the services below are provided as part of your cochlear implant program:

4.2	Cochlear implant evaluation	YES	NO
4.3	Neural response telemetry (NRT)	YES	NO
4.4	Cochlear implant mapping	YES	NO
4.5	Developmental evaluation	YES	NO
4.6	Cochlear Implant Team Management	YES	NO
4.7	Pre-implant psychological assessment	YES	NO

4.8	Speech/Language evaluation	YES	NO
4.9	Speech/Language therapy	YES	NO
4.10	Aural rehabilitation services	YES	NO
4.11	Cochlear implantation surgery	YES	NO
4.12	School site visits for implanted children	YES	NO
4.13	Pre-cochlear implant hearing aid loaner program	YES	NO

Which cochlear implant manufacturers does your facility utilize?

4.14	Cochlear Corporation	YES	NO	4.15	Med-El	YES	NO	4.16	Advanced Bionics	YES	NO
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Section 5 – Hearing Aid Services

5.1 Does your facility provide hearing aid services for **children**?

- YES, all ages (Birth - 21 years)**
 YES, > 1 year ONLY
 YES, > 2 years ONLY
 YES, > 3 years ONLY
 NO

5.2 Are you routinely performing otoscopy to visually inspect for obvious structural abnormalities of the ear canal as well as to ensure there are no contraindications to placing an earphone; probe tip; otoblock and/or impression material prior to audiologic assessment and/or making an impression?

YES **NO**

5.3 Are you an approved vendor with the Special Child Health Services Hearing Aid Assistance Program for children between the ages of birth and 21 years?

YES **NO**

5.4 If you are unfamiliar with the Special Child Health Services Hearing Aid Assistance Program for children between the ages of birth and 21 years, would you like additional information on becoming an approved vendor?

YES **NO**

5.5 Would you consider providing hearing aid services through charitable organizations (e.g., HearNow, Starkey Fund, Public Service Organizations, e.g., Lions, Kiwanis, etc.) for eligible children?

YES NO

5.6 Do you offer “loaner” hearing aids to children?

YES* NO

5.6**If yes, under what circumstances do you offer this service?*

Indicate all procedures or products *currently available* at your office for **children**. Place a check mark (✓) under the heading that applies (No; Yes, but over age 3 only; Yes, any age):

	Yes, all ages (Birth – 21 years)	Yes, > age 1 only	Yes, > age 2 only	Yes, > age 3 only	No
5.7 Real Ear Measurements					
5.8 Desired Sensation Level (DSL)					
5.9 Aided versus unaided soundfield studies					
5.10 Analog hearing aids					
5.11 Digital hearing aids					
5.12 (Conventional) Bone conduction hearing aids					
5.14 Vibrotactile aids					
5.15 Assistive Listening Devices					
5.16 Earmolds					
5.17 Huggie aids					
5.18 Swim molds					
5.19 Pediatric hearing aid care kit (e.g. hearing aid stethoscope, battery tester, dri-aid kit, critter clips, etc.)					

Section 6 – Supplemental Services

6.1 Do you have experience providing hearing health care services for multiply disabled children?

YES* NO

*If yes, check all that apply:

6.2	Vision impairment	YES	NO
6.3	Craniofacial anomalies	YES	NO
6.4	Developmental disabilities	YES	NO

6.5	Cognitive disabilities	YES	NO
6.6	Autism spectrum disorder	YES	NO
6.7	Cerebral palsy	YES	NO

6.8 Does your facility have guidelines for children diagnosed with auditory neuropathy?

YES NO

6.9 Does your facility offer pediatric otolaryngology services on site?

YES NO

6.10 Does your facility offer genetic counseling services on site?

YES NO

- 6.11 Does your facility offer speech/language therapy services on site?
YES NO
- 6.12 Does your facility offer ophthalmology services on site?
YES NO
- 6.13 Does your facility refer families of children with newly identified hearing loss to a parent support program (e.g. Parent-to-Parent)?
YES NO

Section 7 – Accessibility Accommodations

- 7.1 Do you provide information to parents in languages other than English?
YES* NO (If no, skip to question 7.16)

*If yes, please check (✓) below to indicate which languages you offer:

		Written Materials Available	Language Spoken on Site
7.2	Arabic		
7.3	Chinese		
7.4	Gujarti		
7.5	Haitian Creole		
7.6	Korean		
7.7	Polish		
7.8	Portuguese		
7.9	Russian		
7.10	Spanish		
7.11	Urdu		
7.12	AT&T Language Line or other translation services available		
7.13	Other (list all): _____		
7.14	Other: _____		
7.15	Other: _____		

- 7.16 Does your facility provide **qualified** sign language interpreters?
YES NO
- 7.17 Does your facility offer handicapped parking?
YES NO
- 7.18 Is your facility wheelchair accessible?
YES NO
- 7.19 Is your facility easily accessible by public transportation (train/bus stop within 2 blocks)?
YES NO
- 7.20 Does your facility offer evening or weekend hours?
YES NO

Section 8 – Future Educational Opportunities

8.1 Would you be interested in information on available workshops or lectures relating to pediatric audiologic assessment?

YES NO

8.2 Would you be interested in information on available workshops or lectures relating to hearing aid fitting and verification techniques on infants/children under the age of three?

YES NO

8.2 Would you be interested in information regarding working with pediatric patients with multiple disabilities?

YES NO

Section 9 – Insurance Inquiry

Please indicate which insurance providers you currently participate with:

9.1	Aetna Health, Inc.	YES	NO
9.2	Americhoice of New Jersey	YES	NO
9.3	Amerigroup New Jersey	YES	NO
9.4	AmeriHealth HMO	YES	NO
9.5	Charity Care	YES	NO
9.6	Cigna HealthCare of New Jersey	YES	NO
9.7	Coventry Health Care of Delaware	YES	NO
9.8	Empire HealthChoice HMO (Wellchoice)	YES	NO
9.9	Great-West Healthcare of New Jersey (One Health Plan)	YES	NO
9.10	Health Net of New Jersey, Inc	YES	NO
9.11	Horizon (Blue Cross/Blue Shield of New Jersey)	YES	NO
9.12	Medicaid	YES	NO
9.13	Oxford Health Plans (NJ)	YES	NO
9.14	UnitedHealthCare of New Jersey	YES	NO
9.15	University Health Plans	YES	NO
9.16	Other (list all): _____	YES	NO
9.17	Other: _____	YES	NO
9.18	Other: _____	YES	NO
9.19	Other: _____	YES	NO
9.20	Other: _____	YES	NO

Section 10 – Supplemental Questions

10.1 Does your facility offer Tangible Reinforcement Operant Conditioning Audiometry (TROCA)?
 YES
 NO

10.2 Does your facility offer Central Auditory Processing Evaluations?
 YES
 NO

10.3 **Please answer the following questions if your facility provides Baha® (Bone Conduction Implant) services.**

- | | | | |
|------------------------------|------------------------------|------------------------------|------------------------------|
| 1. Baha® evaluation: | 2. Baha® surgery: | 3. Baha® fitting: | 4. Baha® services: |
| <input type="checkbox"/> YES | <input type="checkbox"/> YES | <input type="checkbox"/> YES | <input type="checkbox"/> YES |
| <input type="checkbox"/> NO | <input type="checkbox"/> NO | <input type="checkbox"/> NO | <input type="checkbox"/> NO |

10.4 Is there any additional information you would like to share regarding your facility's pediatric hearing health care services?
