Dear Provider,

_____________________________________________ was identified through a Head Start/Early Head Start audiometric screening at __________________________________________________ as needing a further Head Start Site audiometric follow-up and/or hearing treatment.

Please provide the following information regarding the status of audiometric treatment:

- **Appointment scheduled**
  - Date of appointment: ___________________

- **Treatment in process**
  - Date of next visit: _____________________

  __________________________  __________________________  __________________________

- **Unable to complete treatment for the following reason:**
  - ☐ No show  ☐ Parent declined  ☐ Unable to contact
  - ☐ Other:  ____________________________________________________________

  ____________________________________________________________

  ____________________________________________________________

- **Treatment completed**
  - Date Completed: _______________________

Office/Provider’s Name: ________________________________________  Attn. _______________________

____________________________________________________________ ____________________________

Please sign or use stamp  Date