

## OFFICIAL AUDIOGRAM DATA SHEET

*\*Required Fields*

**\*Name:** \_\_\_\_\_ **\*Family name:** \_\_\_\_\_

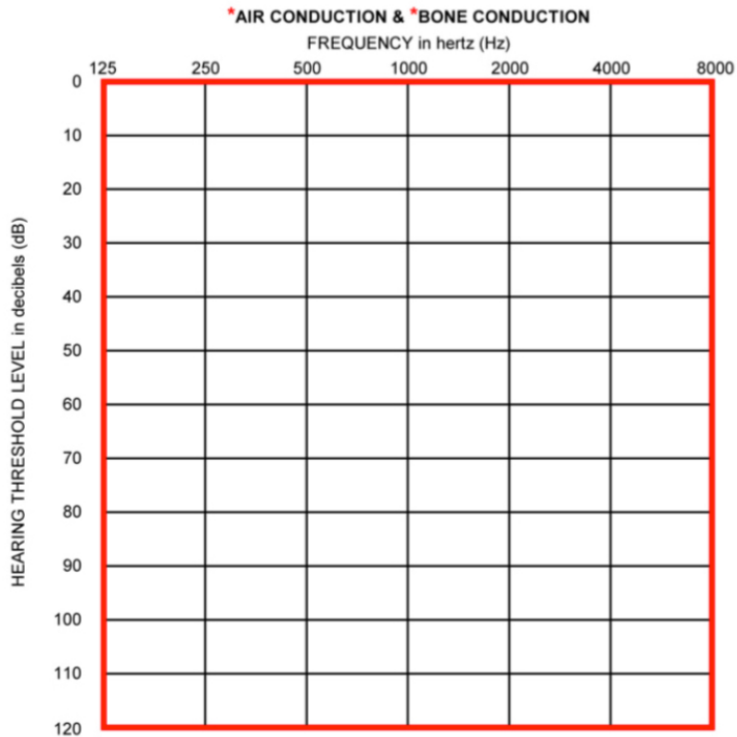
**\*Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_ **\*Nation:** \_\_\_\_\_ **\*Gender:**  Male  Female

**\*Sport:** \_\_\_\_\_ **\*Event:** \_\_\_\_\_

*Below is completed by audiologist only*

**\*Audiometer:** \_\_\_\_\_ **\*Examiner Name:** \_\_\_\_\_

**\*Calibration:**  ANSI 1969  ISO 1964 **\*Date of Examination:** \_\_\_ / \_\_\_ / \_\_\_  
 Other: \_\_\_\_\_



*IMPEDANCE TYMPANOMETRY				
Ear	Canal Vol.	Peak Comp.	Gradient	Pres. Peak
RIGHT				
LEFT				

*REFLEXOMETRY					
Side Equals Probe Ear					
RIGHT	Stim	500	1000	2000	4000
	Ipsi				
	Contra				
LEFT	Stim				
	Ipsi				
	Contra				

KEY TO SYMBOLS				
Ear	Air	Air-masked	Bone	Bone-masked
RIGHT (red)	O	△	<	[
LEFT (blue)	X	□	>	]
		No Response	NR	

PURE TONE AVERAGE (500-1000-2000 Hz)		
Ear	Air	Bone
RIGHT		
LEFT		

TYPE OF HEARING LOSS (Check one for each ear with an "X")				
Ear	Sensory-neural	Conductive	Mixed	Cochlear Implant
RIGHT				
LEFT				

ICSD HOME OFFICE USE ONLY	
ID:	_____
Data Entered By:	_____
ICSD Audiologist:	_____

**This form must be completed three (3) months before the event.**  
 Send this audiogram form to [deafdartsorganisation@gmail.com](mailto:deafdartsorganisation@gmail.com)