Provider Name: Lubna Omar, M.S. CCC-SLP
Title: Speech-Language Pathologist
Company Email: lubna@qcpeds.com
Phone Number: 563-424-2025

Quad Cities Pediatrics P.C. Hearing Screening Consent Form

Patient Information:

- Patient's Name: _____
- Date of Birth: _____
- Parent/Guardian Name: _____
- Contact Information: _____

Purpose of Hearing Screening: I, (Parent/Guardian Name: _____), understand that the purpose of the hearing screening is to assess my child's hearing ability.

Procedure Description: I understand that the hearing screening will be conducted by a qualified healthcare professional at Quad Cities Pediatrics P.C. The procedure typically involves the use of specialized equipment to assess hearing sensitivity. The healthcare professional may ask my child to respond to various auditory stimuli.

Benefits and Risks: I understand that the benefits of the hearing screening include the early detection of hearing issues, which can lead to appropriate interventions if necessary. The risks associated with the hearing screening are minimal and may include discomfort or anxiety during the procedure.

Voluntary Consent: I understand that the hearing screening is voluntary, and I have the right to refuse or discontinue the procedure at any time without prejudice to my (or my child's) medical care.

Confidentiality: I understand that the results of the hearing screening will be kept confidential in accordance with applicable laws and regulations. Only authorized healthcare personnel involved in my child's care will have access to these results.

Alternative Options: I have been informed of alternative options for hearing assessment and have chosen to proceed with the hearing screening at Quad Cities Pediatrics P.C.

Questions and Concerns: I have had the opportunity to ask questions and have received satisfactory answers regarding the hearing screening procedure.

Consent: I hereby give my informed consent for my child to undergo a hearing screening at Quad Cities Pediatrics P.C. I understand the purpose, risks, benefits, and alternatives associated with this procedure.

Patient/Parent/Guardian Signature: _____ (Date)