



Mercy Clinic Ear, Nose and Throat
 1229 E. Seminole, Suite 520
 Springfield, MO 65804
 417-820-5071 phone
 417-820-3757 fax

NAME: _____ DOB: _____

MRN: _____ APPT. DATE: _____ TIME: _____

Pediatric Sedated ABR Instructions

Your child’s doctor has ordered an Auditory Brainstem Response (ABR). An ABR is a non-invasive hearing test. The Audiologist will place electrodes on your child’s head and ears. Insert earphones will be placed in the ear canal and a clicking sound will be presented. This test measures the function of the auditory system at the level of the brainstem in response to the sound. The response is analyzed and the results will be discussed at the end of the test.

Your child will receive a mild sedation to help them sleep during the test. In order for your child to be safely sedated, food and liquids must be limited prior to the administration of the sedative which is a nasal mist. Please follow these steps and allow 4 hours for this test.

1. **Intake of food and milk must stop at:** _____
2. **Intake of all clear liquids (water, apple juice, kool-aid) must stop at:** _____
3. Add an extra feeding or late night snack before the times above to prevent your child from awakening due to extreme hunger/thirst.
If this appointment has been rescheduled from the original day and time, please call the office to be given new times for discontinuing food and liquids.
4. Sleep deprive: get up early, stay up late the night before, no naps.
5. Bring child in comfortable clothes, no ear rings or head bands.
6. Do not use baby oil or lotion to the head or face 24 hrs before the test.
7. Bring a clear liquid for the child to drink after the test.
8. Plan to stay with your child the rest of the day.

Your child will awaken prior to leaving the office at which time they can be given a clear liquid. Your child will most likely be drowsy if not sleep awhile longer. They are not to be taken to day care and should be watched closely and encouraged to drink and eat as tolerated the rest of the day.

Failure to follow these instructions will result in cancellation of this test. Please contact the office if you have questions or your child has been ill or has developed ear/health conditions that might interfere with the test.

Prior to the date of the test, you may want to contact your insurance company to determine if precertification is needed for this evaluation. The procedure code they will need is #92585.

 Parent Signature

 Date

 Print Parent Signature

 Daytime Phone

 Witness Signature

 Date