NEWBORN HEARING SCREENING
Infant Reporting Form

INPATIENT (IP) SCREEN COMPLETED

IP	RIGHT EAR		LEFT EAR	
DATE OF SCREENING				
TYPE OF SCREENING (check one)	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE	☐ ABR ☐ DPOAE ☐ TEOAE
RESULT (check one)	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER	☐ PASS ☐ REFER

***ABR**-Auditory Brainstem Response* ***DPOAE**-Distortion Product Otoacoustic Emission* ***TEOAE**-Transient Evoked Otoacoustic Emission*

INPATIENT SCREEN NOT DONE

☐ Transferred out to (Hospital Name) (Unit) on (*date*):

☐ Missed; discharged without screen ***(Complete Follow-Up section below)***

☐ Waived (Face Sheet not required) - ☐ NHSP Brochure given to parent

☐ Expired or ☐ Not medically indicated for screening per physician determination (Face Sheet not required)

☐ Baby has **Atresia** ☐ Bilateral or ☐ Unilateral **(check one):** ☐ Right ☐ Left ☐ Early Start Referral made

Microtia ☐ Bilateral or ☐ Unilateral **(check one):** ☐ Right ☐ Left

(Complete Follow-Up section below)

FOLLOW-UP FOR REFERS/MISSED

☐ Parent/Legal Guardian information on face sheet verified/updated

Primary Language (Check One): ☐ English ☐ Spanish ☐ Other:

Mother's Race: Mother's Ethnicity: Mother's Education:

☐ Secondary contact information (relative or friend)

Name: **(Other than Parent):** Relationship

Home Phone:( ) Cell Phone ( ) Work Phone ( )

Address: City/Zip:

Primary Language (Check One): ☐ English ☐ Spanish ☐ Other:

☐ **Print Infant's Full/Legal Name:**

☐ NHSP Brochure given to parent (check one): ☐ Refer ☐ Refer to DX

☐ Follow-Up Appointment made and written on parent brochure:

APPOINTMENT: ☐ **OP** SCREENING ☐ **DX** EVALUATION for Atresia or Microtia OR per Physician Determination

DATE: **TIME:** ☐ **CA Children's Services (CCS) Referral Made–County**:

PROVIDER: **Phone:** ( )

☐ PCP who will see the Infant after discharge – Name: Phone: ( )

☐ Completed form **faxed *with hospital face sheet*** to the Northern California Hearing Coordination Center, Fax No. (800) 866-1074. HCC contact phone No. (800) 645-3616, press #3.

Patient Name: **Medical Record Number:**

Birth Date: **Submitting Hospital Name:**

☐ **WBN** ☐ **NICU Gest. Age @ birth: wks** **Gender: Male Female**

Birth Hospital