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 Southeastern California Hearing Coordination Center, Fax No. (909) 498-7982. HCC contact phone No. (909) 793-1291

Patient Name: _____ **Medical Record Number:** _____

Birth Date: _____ **Submitting Hospital Name:** _____

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

Birth Hospital _____