NEWBORN HEARING SCREENING
Infant Reporting Form

California Newborn Hearing Screening PROGRAM

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 Southern California Hearing Coordination
Center, Fax No. (661) 244-2856. HCC contact phone No. (661) 591-4300

Patient Name: **Medical Record Number:**

Birth Date: **Submitting Hospital Name:**

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

Birth Hospital