



California Newborn Hearing Screening Program Outpatient Screening Reporting Form

Please complete this form and Fax to (800) 866-1074 or Mail to the Northern California Hearing Coordination Center, 1501 Industrial Road, San Carlos, CA 94070, within seven days of the child's outpatient hearing screening. DO NOT attach waveforms, OAE printout, audiograms or reports. If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center at (800) 645-3616, press #3.

I. Screening Provider: _____ Phone: _____ Fax: _____

Infant's Name: _____ Date of Screen: _____

AKA: _____ Date of Birth: _____ Gender: Female Male

Primary Care Provider (PCP): _____ Phone: _____

Birth Hospital: _____ WBN NICU County: _____

Insurance: Medi-Cal HMO Private Insurance Uninsured Unknown

Mother's Name (or Legal Guardian): _____

Address: _____ Phone Number: _____

Primary Language: English Spanish Other (specify) _____

Comments: _____

II. Screening Results: Initial Screen (1st, no previous screening inpatient or outpatient) Re-screen (2nd)

	DPOAE	TEOAE	ABR(Screening)
Right Ear	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer
Left Ear	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer

III. For infants who do not pass the outpatient screening:

Referral to CCS

Name of County: _____ Date: _____

Family's CCS application was forwarded to local CCS program Yes No

Referred for Diagnostic Evaluation

Name of Provider: _____ Phone: _____

Date of Appointment: _____ Reason appointment not scheduled: _____

Contact Information (Relative or Friend):

Name: _____ Phone: _____

Address: _____ Relationship: _____

IV. Parent/Guardian Refused Services: Yes Refused by: _____

V. Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family.

1. Contact: Mail Phone Fax Date _____ Result: _____

2. Contact: Mail Phone Fax Date _____ Result: _____

3. Contact: Mail Phone Fax Date _____ Result: _____

This information is to be provided pursuant to Section 124119 of the California Health and Safety Code that requires you to report the results of audiological follow-up services provided through the California Newborn Hearing Screening Program.