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.**

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: ____

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

	DPOAE	TEOAE	ABR(Screening)
Right Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer
Left Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ 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.