California Newborn Hearing Screening Program
Diagnostic Audiologic Evaluation Reporting Form

Please complete this form and Fax to 909-498-7982 or Mail to the South Eastern Hearing Coordination Center, 1200 California Street, Suite 108, Redlands CA 92374, within seven days of the child's diagnostic Audiologic Evaluation. 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 audiology evaluation please contact the Hearing Coordination Center at 909-793-1291.**

Infant's Name: ______________________ Date of Birth: __________ Date of Eval.: ______________

AKA: ______________________ Gender: ☐ F ☐ M Medical Record No.: ______________________

Birth Hospital: ______________________ ☐ WBN ☐ NICU Family Language: ______________

Primary Care Provider (PCP): ______________________ Phone: ______________________

Parent or Legal Guardian: ______________________ Phone: ______________________

Address: ____ Zip: ______________

Test Results: Diagnostic evaluations should be completed as per the California Infant Audiology Assessment Guidelines and the Joint Committee on Infant Hearing Year 2007 Position Statement.

Test Results		RIGHT	LEFT
	Average/Estimated Hearing Level (500-4kHz)	☐ Normal -10-15 dB ☐ Slight 16-25 dB ☐ Mild 26-40 dB ☐ Moderate 41-55 dB ☐ Moderately-Severe 56-70 dB ☐ Severe 71-90 dB ☐ Profound 91+ dB	☐ Normal -10-15 dB ☐ Slight 16-25 dB ☐ Mild 26-40 dB ☐ Moderate 41-55 dB ☐ Moderately-Severe 56-70 dB ☐ Severe 71-90 dB ☐ Profound 91+ dB
	Type of Hearing Loss *Leave blank if hearing is normal*	☐ SNHL ☐ CHL ☐ permanent ☐ transient ☐ Mixed ☐ Auditory Neuropathy/Dys-synchrony ☐ Undetermined/testing not completed next appt❖: ______________	☐ SNHL ☐ CHL ☐ permanent ☐ transient ☐ Mixed ☐ Auditory Neuropathy/Dys-synchrony ☐ Undetermined/testing not completed next appt❖: ______________

❖ Should be scheduled ASAP. Program goals include diagnosis of hearing loss by 3 months of age and entry into Early Intervention services by 6 months.

Atresia R☐ L☐ **Microtia R☐ L☐**

Amplification Recommended (Y/N) Discussion: ______________________________________

Other Diagnosis Related to Hearing Loss, Discussion: ______________________________________

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Parent/Guardian Refused Diagnostic Services: Refused by: ______________________ Date: __________

Plan/Follow-up appt.: ____

Referral to ENT: Date: ______ Physician: ______________________ Phone: ______________

Referral to CCS: Date: ______ ☐ Application ☐ SAR ☐ County: ______________________

Referral to Early Start (1-866-505-9388): Date: ______________________________________

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

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Audiology Facility: ______________________________ Phone: __________ Fax: __________

Audiologist Name (Print) ______________________ Signature ______________________ Lic.# __________

Please complete all relevant information. Incomplete forms will be returned.

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. NHSP 300-1 Region C Rev 7/15