



California Newborn Hearing Screening Program

Diagnostic Audiologic Evaluation Reporting Form

Please complete this form and Fax to 661-244-2865 or Mail to the Southern California Hearing Coordination Center, 1 Centerpointe Drive, Suite 410, La Palma, CA 90623, 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 661-591-4300.

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.

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

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:

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.