Hearing Screen Form

NEWBORN'S INFORMATION: ***(Please Print)***

____
Newborn's Last Name

____
Newborn's First Name

____
Birth Order *(if a multiple)*

Date of Birth____________________________
MM-DD-YY

____
Birth Hospital

____
Newborn's Hospital Medical Record #

MOTHER'S INFORMATION:

____
Mother's Last Name

____
Mother's First Name

____
Mother's Social Security Number ***(please provide entire number- not just the last 4 digits)***

HEARING SCREEN RESULTS:

Date of Hearing Screen __________________________
MM-DD-YY

Right Ear
_____ Pass
_____ Refer

Left Ear
_____ Pass
_____ Refer

Last Test Method(s) used:

Right Ear
_____ OAE
_____ ABR

Left Ear
_____ OAE
_____ ABR

Comments/Special Instructions:

____
____
____

Follow-up Appt.:
Date: ____________________
Time: ____________________
Location: _________________

Hearing risk status – Check all that apply:
_____ Family history (blood relative with permanent hearing loss in early childhood, e.g. grandparent, parent, aunt, uncle, first cousin, siblings)
_____ PPHN
_____ ECMO
_____ Exchange transfusion for hyperbilirubinemia
_____ Birth weight less than 1500 grams
_____ NICU

Adhere facility bar code label here: (optional)

____
Person Completing Form

____
Facility

(___)__________ext.____
Phone Number

Fax to Newborn Screening Unit (850) 245-4049