

How To Report Hearing Screen Results on the Florida Newborn Screening Metabolic Specimen Collection Card (formerly PKU)

1) Do not touch sample area

PLEASE FILL IN THIS CARD USING CAPITAL LETTERS ONLY. ALL FIELDS MUST BE FILLED OUT COMPLETELY TO AVOID DELAY. ILLEGIBLE HANDWRITING AND INCOMPLETE INFORMATION WILL RESULT IN DELAYS. DARKEN ALL CIRCLES THAT APPLY: REFUSED INFORMATION ONLY STATUS: DECEASED ADOPTION NICU MEDICUM ILEUS confirmed/unconfirmed

INFANT'S INFORMATION

Infant's Last Name: _____ Infant's First Name: _____ Hospital of Birth: _____ Infant's Medical Record Number: _____

Date of Birth: [M][M][D][D][Y][Y] Birth Time (hh:mm): [H][H][M][M] Birth Wt. (gms): [M][M][D][D][Y][Y] Gender: [M][F][U] Birth Order: [A][H] Week of Gestation: [M][M][D][D][Y][Y] Collection Date: [M][M][D][D][Y][Y] Time (hh:mm): [H][H][M][M] Collection Wt. (gms): [M][M][D][D][Y][Y] Collected by (s): [M][M][D][D][Y][Y] Transfusion Date: [M][M][D][D][Y][Y] Title (initials): [H][H][M][M]

MOTHER'S/FATHER'S CONTACT

Mother's Last Name: _____ Mother's First Name: _____ Mother's Date of Birth: [M][M][D][D][Y][Y] Mother's or Contact's Telephone Number: [M][M][D][D][Y][Y] _____

Mother's Address (include Apartment Number): _____ City: _____ State: _____ Zip Code: _____ Alternate Telephone Number: _____

INSURANCE INFORMATION

Insured's Name (Last, First & Middle Initial): [M][M][D][D][Y][Y] Relationship to Insured: SELF CHILD Name of Insurance Company: _____

Insured's Date of Birth: [M][M][D][D][Y][Y] Insurance Group ID#: _____

PRIMARY CARE / FOLLOW UP PHYSICIAN INFORMATION

Physician's Last Name: _____ First Name: _____ Physician's Telephone Number: [M][M][D][D][Y][Y] _____

ORDERING PHYSICIAN INFORMATION

Physician's Last Name: _____ First Name: _____ NPI Number: _____

COLLECTION FACILITY INFORMATION

Collection Facility Name: _____ Laboratory ID#: _____

MAIL TO (SUBMITTER INFORMATION)

Facility Name (Hospital or Clinic): _____ City: _____ State: _____ Zip Code: _____

Address: _____

Darken ALL circles that apply at time of collection:

SPECIMEN INFORMATION NATAL REPEAT

FEED STATUS: NFD ORAL IPN / HYPERAL

RACE: WHITE BLACK HISPANIC AMERICAN INDIAN/ALASKA NATIVE PACIFIC ISLANDER OTHER

PULSE OXIMETRY [M][M][D][D][Y][Y] [H][H][M][M] DATE TIME (hh:mm)

HEARING SCREENING [M][M][D][D][Y][Y] DATE

HEARING RISK STATUS: NICU > 5 DAYS ECMO PPHN FAMILY HISTORY CMV BIRTH WEIGHT < 1500 GRAMS EXCHANGE TRANSFUSION FOR HYPERBILIRUBINEMIA

NOT SCREENED BEFORE DISCHARGE REASON: (Select one) MICROTIA / ATRESIA / CLEFT FACILITY TRANSFER EXPIRED PROLONGED NICU STAY MISSED MEDICALLY FRAGILE REFUSED

MAIL SPECIMENS TO: STATE OF FLORIDA-BUREAU OF PUBLIC HEALTH LABORATORIES 1217 N PEARL ST. JACKSONVILLE, FL 32202 (904) 791-1645

Neonatal Screening Specimen Collection Card, 04/16/17, Replaces ALL Previous Editions. Conforms to CLSI Standards, Rule H03-T-000, F.A.C.

EXPIRED CARDS WILL BE REJECTED

STATE LAB USE ONLY

STATE LAB USE ONLY

HEARING SCREENING

[M][M][D][D][Y][Y] DATE

LEFT EAR PASS FAIL OAE ABR VI

RIGHT EAR PASS FAIL OAE ABR VI

Hearing Screening

1. Enter the date of the final hearing screen performed inpatient.
2. Darken the circle for final hearing screen results for left and right ears.
 - o In case of ear malformation, darken FAIL (needs further testing/an audiology referral)
3. Darken the circle for the method used, either ABR, OAE or VI
 - o VI stands for Visual Inspection – All ear malformations should be documented as VI with a fail result for both ears.
4. Do not handwrite hearing results/method on the card.

HEARING RISK STATUS:

NICU > 5 DAYS ECMO PPHN FAMILY HISTORY CMV BIRTH WEIGHT < 1500 GRAMS EXCHANGE TRANSFUSION FOR HYPERBILIRUBINEMIA

Hearing Risk Status: Darken ALL that apply.

1. NICU > 5 days when patient received care in neonatal intensive care unit greater than 5 days.
2. ECMO when patient has a condition that required use of extracorporeal membrane oxygenation.
3. PPHN when patient has persistent pulmonary hypertension associated with mechanical ventilation.
4. Family history when patient has a parent, grandparent, sibling, aunt, uncle, first cousin with permanent childhood hearing loss.
5. CMV positive following confirmatory testing.
6. Birth Weight when patient weighed < 1500 grams at birth.
7. Exchange transfusion for hyperbilirubinemia when the patient had a transfusion to treat hyperbilirubinemia.

NOT SCREENED BEFORE DISCHARGE REASON: (Select one)

MICROTIA / ATRESIA / CLEFT FACILITY TRANSFER EXPIRED PROLONGED NICU STAY MISSED MEDICALLY FRAGILE REFUSED

Not Screened Before Discharge Reason

Darken the circle to indicate the reason a hearing screening was not performed before discharge using the following definitions:

- a. Microtia/Atresia/Cleft: Hearing screen cannot be performed due to ear abnormality.
- b. Facility Transfer: Patient transferred to another hospital before completing a hearing screen.
- c. Expired: Patient passed away.
- d. Prolonged NICU Stay: Baby received care in the NICU greater than 5 days.
 - Once patient meets criteria established by hospital or medical provider, a hearing screen should be performed and reported.
- e. Missed: Hearing screen was not completed while inpatient before discharge
- f. Medically Fragile: Patient with a medical condition that requires equipment or procedures to sustain life, e.g., ventilator dependent, and are not likely to receive an inpatient hearing screen.
- g. Refused: Parent or legal guardian refused hearing screen inpatient.