

Newborn Hearing Screening Infant Reporting

ABR-Auditory Brainstem Response, DPOAE-Distortion Product Otoacoustic Emission, TEOAE-Transient Evoked Otoacoustic Emission, NHSP-Newborn Hearing Screening Program

Inpatient (IP) Screen Completed

IP	Right Ear		Left Ear	
Date of Screening				
Type of Screening (check one)	ABR DPOAE TEOAE	ABR DPOAE TEOAE	ABR DPOAE TEOAE	ABR DPOAE TEOAE
Result (check one)	PASS REFER	PASS REFER	PASS REFER	PASS REFER

IP Screen Not Done

Transferred out to
(Hospital Name) _____ (Unit) _____ on (date): _____

Missed or discharged without screen (Complete Follow-Up section below)

Waived (Face Sheet not required) NHSP brochure given to parent

Expired Not medically indicated for screening per physician determination
(Face Sheet not required)

Baby has Atresia Bilateral or Unilateral (check one): Right Left
 Microtia Bilateral or Unilateral (check one): Right Left

Early Start Referral made

(Complete Follow-Up section below)

Follow-Up for Referrals/Missed

Parent/Legal Guardian information on face sheet verified/updated

Primary Language (Check One): English Spanish

Other: _____

Mother's Race: _____ Mother's Ethnicity: _____

Mother's Education: _____

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Secondary contact information (relative or friend)

Name: (Other than Parent): _____ Relationship _____

Home Phone: _____ Cell Phone _____ Work Phone _____

Address: _____ City: _____ Zip: _____

Primary Language (Check One): English Spanish Other: _____

Print Infant's Full/Legal Name: _____

NHSP Brochure given to parent (check one): Refer Refer to Diagnostic Evaluation (DX)

Follow-Up Appointment made and written on parent brochure:

APPOINTMENT: OP SCREENING	DX for Atresia or Microtia OR per Physician Determination
DATE: _____ TIME: _____	CA Children's Services (CCS) Referral Made County: _____
PROVIDER: _____	PHONE: _____

Primary Care Physician who will see the Infant after discharge –

Name: _____ Phone: _____

Completed form faxed with hospital face sheet to the Northern California Hearing Coordination Center (HCC)

Fax No.: (800) 866-1074

HCC Phone No.: (800) 645-3616, press #3

Secure email: HCCNorthern@natus.com

Patient Name: _____ Medical Record Number: _____

Birth Date: _____ Submitting Hospital Name: _____

Well Baby Nursery Neonatal Intensive Care Unit Gestation Age at birth: ___ weeks

Birth Hospital: _____

What sex was listed on infant's birth certificate: _____