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:_____

Phone: (916) 327-1400
Internet Address: http://www.DHCS.ca.gov

Newborn Hearing Screening
Infant Reporting

☐ 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
DATE:_____ TIME:_____

☐ DX for Atresia or Microtia OR per Physician Determination
☐ 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 Southern California Hearing Coordination Center (SCHCC)
Fax No.: (909) 498-7982
HCC Phone No.: (909) 793-1291
Secure email: southern.hcc@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:_____

Phone: (916) 327-1400
Internet Address: http://www.DHCS.ca.gov