California Newborn Hearing Screening Program
Diagnostic Audiologic Evaluation Reporting

Please complete all relevant information and submit within 7 days of child's Diagnostic Audiologic Evaluation. Incomplete forms will be returned.

Acronyms defined: AKA-Also Known As, WBN-Well Baby Nursery, NICU-Neonatal Intensive Care, SNHL-Sensorineural Hearing Loss, CHL-Conductive Hearing Loss, ENT-Ear, Nose, and Throat specialist, CCS-California Children's Services, SAR-Service Authorization Request, OAE-Otoacoustic Emissions

Infant's Name:__________________________ Date of Birth:__________ AKA:________________

What sex is listed on infant's birth certificate:_________________ Date of Evaluation:__________

Birth Hospital:_________________________________ WBN NICU

Family Language:___________________ Medical Record Number:

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 2019 Position Statement.

Test Results		Right	Left
	Average/ Estimated Hearing Level (500-4kHz)	Normal -10-15 dB Slight 16-25 dB Mild 26-40 dB Moderate 41-55 dB Moderately-Severe 56-70 dB Severe 71-90 dB Profound 91+ dB	Normal -10-15 dB Slight 16-25 dB Mild 26-40 dB Moderate 41-55 dB Moderately-Severe 56-70 dB Severe 71-90 dB Profound 91+ dB
	Type of Hearing Loss *Leave blank if hearing is normal*	SNHL CHL permanent transient Mixed Auditory Neuropathy/ Dys-synchrony Undetermined/testing not completed next apt*:________________	SNHL CHL permanent transient Mixed Auditory Neuropathy/ Dys-synchrony Undetermined/testing not completed next apt*:__________________

*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.

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Atresia R L Microtia R L
Amplification Recommended: Yes ___ No____
Amplification Discussion:____

Other Diagnosis Related to Hearing Loss, Discussion:__________________________________

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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 (1-916-282-2440) or https://leadkfamilyservices.org/earlystartreferral/ :

Date:___________

Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family:

________________________ ________________________ _________________________

Audiology Facility:______________________________ Phone:_______________ Fax:_____________

Audiologist Name (print):____________________________ Signature:________________________

License Number:_______________

Please complete this form and **fax to (800) 866-1074 or Secure email to HCCNorthern@natus.com or mail to the Northern California Hearing Coordination Center, 5627 Stoneridge Dr, Suite #308, Pleasanton, CA 94588**, 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 (800) 645-3616, press #3

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.