NEWBORN HEARING SCREENING
Infant Reporting Form

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

***ABR**-Auditory Brainstem Response* ***DPOAE**-Distortion Product Otoacoustic Emission* ***TEOAE**-Transient Evoked Otoacoustic Emission*

INPATIENT SCREEN NOT DONE

☐ Transferred out to (Hospital Name) _____ (Unit)_____on (*date*): _____

☐ Missed; discharged without screen ***(Complete Follow-Up section below)***

☐ Waived (Face Sheet not required) - ☐ NHSP Brochure given to parent

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

☐ Baby has **Atresia** ☐ Bilateral or ☐ Unilateral **(check one):** ☐ Right ☐ Left ☐ Early Start Referral made

Microtia ☐ Bilateral or ☐ Unilateral **(check one):** ☐ Right ☐ Left

(Complete Follow-Up section below)

FOLLOW-UP FOR REFERS/ MISSED

☐ Parent/Legal Guardian information on face sheet verified/updated
Primary Language (Check One): ☐ English ☐ Spanish ☐ Other: _____

☐ 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 DX

☐ Follow-Up Appointment made and written on parent brochure:

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

☐ PCP who will see the Infant after discharge – Name: _____Phone: (____) _____

☐ Completed form **faxed *with hospital face sheet*** to the Southern California Hearing Coordination Center,
Fax Number: (800) 866-1074 HCC Telephone Number: (800) 645-3616, Press #3

Patient Name: _____

Birth Date: _____

☐**WBN** ☐ **NICU Gest. Age @ birth:** _____**wks**

Birth Hospital if different_____