

## California Newborn Hearing Screening Program Outpatient Screening Reporting Form

<u>Please complete this form and Fax to</u> (800) 866-1074 or <u>Mail</u> to the Northern California Hearing Coordination Center, 1501 Industrial Road, San Carlos, CA 94070, within seven days of the child's outpatient hearing screening. <u>DO NOT attach waveforms</u>, OAE printout, audiograms or reports. If the family does not appear for the scheduled appointment and you have difficulty in rescheduling the outpatient hearing screening, please contact the Hearing Coordination Center at (800) 645-3616.

Infant's Name:	I. Screening Provider:		Phone:		Fax:
Primary Care Provider (PCP): Phone:	Infant's Name:				
Birth Hospital:	AKA:		Date of Birth:	Gender:	□Female □Male
Insurance:   Medi-Cal   HMO   Private Insurance   Uninsured   Unknown	Primary Care Provider (PCP):			Phone:	
Mother's Name (or Legal Guardian):  Address:	Birth Hospital:		BN 🗆 NICU County	y:	
Address:	Insurance: □Medi-Cal □	HMO □Private Insura	ance	□Unknown	
Address:	Mother's Name (or Legal Guardia	an):			
II. Screening Results:					
II. Screening Results:   Initial Screen (1st, no previous screening inpatient or outpatient)   Re-screen (2nd)	Primary Language: □English □	□Spanish □Other (spe	cify)		
II. Screening Results:   Initial Screen (1st, no previous screening inpatient or outpatient)   Re-screen (2nd)	Comments:				
DPOAE   TEOAE   ABR(Screening)   Right Ear   Pass   Refer   Pass   Pass	Comments.				
Right Ear	II. Screening Results:   Initial Initi	tial Screen (1 <sup>st</sup> , no previo	ous screening inpatien	t or outpatient) 🛚 R	e-screen (2 <sup>nd</sup> )
Left Ear		DPOAE	TEOAE	ABR(Screening)	$\neg$
III. For infants who do not pass the outpatient screening:  Referral to CCS  Name of County:	Right Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer	
Referral to CCS  Name of County:	Left Ear	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer	
Referral to CCS  Name of County:	III. For infants who do not p	ass the outpatient so	creenina:		
Name of County:			<u> </u>		
Phone:	<u> </u>				
Referred for Diagnostic Evaluation  Name of Provider: Phone:  Date of Appointment: Reason appointment not scheduled:  Contact Information (Relative or Friend): Phone:  Name: Phone:  Address: Relationship:					
Name of Provider: Reason appointment not scheduled: Contact Information (Relative or Friend):  Name: Phone:			S program □Yes	□No	
Date of Appointment: Reason appointment not scheduled:	Referred for Diagnostic Eva	<u>lluation</u>			
Contact Information (Relative or Friend):   Name: Phone:   Address: Relationship:    IV. Parent/Guardian Refused Services:     Yes   Refused   By:					
Name: Phone: Address: Relationship:  IV. Parent/Guardian Refused Services:      Yes   Refused by:	Date of Appointment:	Reason appo	ointment not scheduled	l:	
Address: Relationship:  IV. Parent/Guardian Refused Services:   Yes Refused by:	Contact Information (Relative	ve or Friend):			
IV. Parent/Guardian Refused Services:    Yes Refused by:	Name:			Phone:	
IV. Parent/Guardian Refused Services:   Yes Refused by:			Relationship:		
			efused by:		
			•		
V. Parent/Guardian Contact Attempts: Document at least 3 attempts to contact the family.  1. Contact: □ Mail □ Phone □ Fax Date Result:	V. Parent/Guardian Contact	Attempts: Documer	nt at least 3 attempt	s to contact the fa	nmily.
2. Contact:  Mail Phone Fax Date Result: Result:					
3. Contact: ☐ Mail ☐ Phone ☐ Fax Date Result:					

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.