California Newborn Hearing Screening Program
Infant Reporting Form

Acronyms defined: ABR (Auditory Brainstem Response), DPOAE (Distortion Product Otoacoustic Emission), IRF (Infant Reporting Form), TEOAE (Transient Evoked Otoacoustic Emission), NHSP (Newborn Hearing Screening Program), IRF (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

IP Screen Not Done

☐ Transferred out to

Hospital Name:_____ Unit:_____ 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

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:_____

Infant Name (First):_____ (Last):_____

Infant Date of Birth:_____

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Secondary contact information (relative or friend)

Name Other than Parent (First):_____ (Last):_____

Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Address:_____City:_____ Zip:_____

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

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

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

APPOINTMENT:

Date:_____ Time:_____

Phone:_____

Provider:_____

☐ OP Screening

☐ DX for Atresia or Microtia OR per Physician Determination

☐ CA Children's Services (CCS) Referral Made County:

Primary Care Physician who will see the Infant after discharge –

Name (First): _____ (Last)_____ Phone:_____

☐ Completed form **faxed with hospital face sheet** to Southern California Hearing Coordination Center (SCHCC)

Fax No.: (909) 498-7982

HCC Phone No.: (909) 793-1291

Secure email: southern.hcc@natus.com

Patient Information

Infant's Name (First):_____ (Last): _____

Date of Birth: _____ Submitting Hospital:_____

☐ Well Baby Nursery ☐ Neonatal Intensive Care Unit Gestation Age at birth:___weeks

Birth Hospital:_____

Sex listed on infant's birth certificate:_____