California Newborn Hearing Screening Program
Outpatient Reporting Form

Please complete all relevant information and submit within 7 days of child's outpatient hearing screening.

Acronyms defined: ABR (Auditory Brainstem Response), AKA (Also Known As), CCS (California Children's Services), DPOAE (Distortion Product Otoacoustic Emission), HMO (Health Maintenance Organization), NICU (Neonatal Intensive Care), OAE (Otoacoustic Emissions), ORF (Outpatient Reporting Form), TEOAE (Transient Evoked Otoacoustic Emission), WBN (Well Baby Nursery)

I. Patient Information

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

AKA:_____ Date of Birth:_____

What sex is listed on infant's birth certificate:_____

Mother's First Name (or Legal Guardian):_____

Last Name:_____ Phone:_____

Address:_____ City:_____

Zip code:_____

Primary language: ☐ English ☐ Spanish ☐ Other (specify):_____

Birth hospital:_____ County:_____

☐ WBN ☐ NICU Medical Record Number:_____

Insurance: ☐ Medi-Cal ☐ HMO ☐ Private Insurance ☐ Uninsured ☐ Unknown

II. Screening

Screening Provider:_____ Screening Date:_____

Primary Care Provider: _____

Phone:_____ Fax:_____

Comments:_____

II. Screening Results

☐ Initial Screen (1st, no previous screening inpatient or outpatient) ☐ Re-screen (2nd)

Ear	DPOAE	TEOAE	ABR(Screening)
Right	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer
Left	☐ Pass ☐ Refer	☐ Pass ☐ Refer	☐ Pass ☐ Refer

NHSP Phone: (877) 388-5301
https://www.dhcs.ca.gov

California Newborn Hearing Screening Program Outpatient Screening Reporting

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

Date of Birth:_____

III. Screening, Refer to CCS

Name of County:		Date:
Family's CCS application was forwarded to local CCS Program: Yes ☐ No ☐		
Referred for Diagnostic Evaluation		
Name of Provider:		Date of Appointment:
Reason not scheduled:		Phone:
Contact Information (Relative or Friend)		
Name (First):	(Last):	
Phone:	Relationship:	
Address:		City:
Zip Code:		State:

IV. Parent/Guardian Refused Services

Yes ☐ Refused by (First Name):_____(Last Name):_____

V. Parent/Guardian Contact Attempts

Document at least 3 attempts to contact the family.

Contact by ☐ Mail ☐ Phone ☐ Fax Date:_____ Result:_____

Contact by ☐ Mail ☐ Phone ☐ Fax Date:_____ Result:_____

Contact by ☐ Mail ☐ Phone ☐ Fax Date:_____ Result:_____

Please complete this form and fax to **(800) 866-1074 or Secure email to southern.hcc@natus.com or mail to the Southern California Hearing Coordination Center, 1200 California Street, Suite 108, Redlands CA 92374** within seven days of the child's outpatient hearing screening. 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 outpatient hearing screening, please contact the Hearing Coordination Center at (800) 745-3616, 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.