

Infant Hearing Initial Screening											
Child Last Name:						Date of Birth:					
Child First Name:						Child Medical Record #					
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Gestational Age:		Birth Weight:		Plurality:		1) Single 2) Twins 3) Triplets 4) Quadruplets 5) Quintuplets 6) Sextuplets 7) Septuplets 8) Octuplets 9) Unknown			
Birth Hospital:						Birth Facility #:					
Transferred to:											
PCP Group:										Home Birth: <input type="checkbox"/>	
Contact Information: <i>Please identify contact as</i> Mother <input type="checkbox"/> Agency <input type="checkbox"/> Guardian <input type="checkbox"/> Adoption Pending <input type="checkbox"/>											
Last Name:						Mo. Medical Record #:					
First Name:						If guardian, relationship to child:					
Contact's Primary Language: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/>						Biological Parent: Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/>					
Address Line 1:						Primary Phone Number:					
Address Line 2:											
City:						Alternate Phone Number:					
State:						Zip Code:					
Second Contact											
Last Name:						Relationship to Child:					
First Name:						Primary Phone:					
						Alternate Phone:					
Screening Information											
Screening Facility Name (if different from Birth Facility):						Screening Date:					
						Screening Facility #:					
Tester First Initial:		Tester Last Name:				Tester Title:					
Basic Insurance Type: Public <input type="checkbox"/> Private <input type="checkbox"/> Self Pay <input type="checkbox"/>						Has this baby been discharged once since birth? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Risk Factors: Immediate Neonatal Period						Risk Factors: After Immediate Neonatal Period					
<input type="checkbox"/> Family history of permanent childhood hearing loss <input type="checkbox"/> NICU Admission of more than 5 days <input type="checkbox"/> ECMO <input type="checkbox"/> Assisted ventilation <input type="checkbox"/> Ototoxic medications <input type="checkbox"/> Loop diuretics <input type="checkbox"/> Hyperbilirubinemia requiring exchange transfusion <input type="checkbox"/> Suspected in-utero infections (e.g. CMV, herpes, rubella, syphilis, toxoplasmosis) <input type="checkbox"/> Craniofacial anomalies including involvement of the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies						<input type="checkbox"/> Caregiver concerns about hearing, speech, language, or developmental delay <input type="checkbox"/> Physical finding associated with a syndrome involving hearing loss (e.g. white forelock) <input type="checkbox"/> Neurodegenerative disorder <input type="checkbox"/> Post-natal infections (e.g. herpes, varicella, meningitis) <input type="checkbox"/> Head trauma <input type="checkbox"/> Diagnosed Cytomegalovirus (CMV) <input type="checkbox"/> Chemotherapy					
Screening Method and Test Results											
Method of Screening: OAE <input type="checkbox"/> AABR <input type="checkbox"/>											
Left Ear: Pass <input type="checkbox"/> Fail <input type="checkbox"/> DNT <input type="checkbox"/> Reason ()			Please indicate reason for DNT(Did Not Test): Equipment Down(1) Discharge before Test(2) Emergency Transfer(3)								
Right Ear: Pass <input type="checkbox"/> Fail <input type="checkbox"/> DNT <input type="checkbox"/> Reason ()			Infant Expired(4) Parental Refusal(5) Atresia(6) Non-Hospital Birth(7) Previously Passed(8)								
Infant Hearing Appointment Scheduling <i>(As indicated, please make appointment for either a Rescreen or Diagnostic Test Battery)</i> Comfort Care Discharge <input type="checkbox"/>											
Post-discharge Initial Screen <input type="checkbox"/> Rescreen <input type="checkbox"/> Diagnostic Test Battery <input type="checkbox"/>						Appointment Date:					
Hospital or Clinic Name (if different from Birth Facility):						Appointment Time:					
						AM <input type="checkbox"/> PM <input type="checkbox"/>					
PCP Group Referral sent to:											