

Infant Hearing Post-Discharge Initial Screen or Rescreen											
PDIS <input type="checkbox"/> Rescreen <input type="checkbox"/>						Screening Date: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
Reference Info Update: Is the infant's name the same as that recorded at birth? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the Mother/Guardian/Agency's contact information the same as that recorded at birth? Yes <input type="checkbox"/> No <input type="checkbox"/>											
Child Last Name: <input type="text"/>						Date of Birth: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
Child First Name: <input type="text"/>						Sex: M <input type="checkbox"/> F <input type="checkbox"/>					
Contact Information: Please identify contact as Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Agency <input type="checkbox"/> Adoption Pending <input type="checkbox"/>											
Last Name: <input type="text"/>						Primary Phone Number: <input type="text"/>					
First Name: <input type="text"/>						Alternate Phone Number: <input type="text"/>					
Address Line 1: <input type="text"/>						Address Line 2: <input type="text"/>					
City: <input type="text"/>						State: <input type="text"/>		Zip Code: <input type="text"/>			
Birth Facility Name: <input type="text"/>						Birth Facility Number: <input type="text"/> - H					
PCP Group Name: <input type="text"/>											
Screening Information											
Tester First Initial: <input type="text"/>			Tester Last Name: <input type="text"/>						Tester Title: <input type="text"/>		
Screening Facility Name (if different from Birth Facility): <input type="text"/>											
						Screening Facility #: <input type="text"/> - <input type="text"/>					
Basic Insurance Type: Public <input type="checkbox"/> Private <input type="checkbox"/> Self-Pay <input type="checkbox"/>											
Risk Factors: After Immediate Neonatal Period											
<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"/>				Please indicate reason for DNT (Did Not Test): Equipment down <input type="checkbox"/> Previously passed <input type="checkbox"/> Other <input type="checkbox"/>							
Right Ear: Pass <input type="checkbox"/> Fail <input type="checkbox"/> DNT <input type="checkbox"/>				Please indicate reason for DNT (Did Not Test): Equipment down <input type="checkbox"/> Previously passed <input type="checkbox"/> Other <input type="checkbox"/>							
Infant Hearing Appointment Scheduling											
If baby has failed Rescreening OR was admitted to NICU for more than 5 days and failed PDIS, please make an appointment for a Diagnostic Test Battery.											
Diagnostic Test Battery Clinic Name: <input type="text"/>						Appointment Date: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
						Appointment Time: <input type="text"/> : <input type="text"/> AM <input type="checkbox"/> PM <input type="checkbox"/>					
PCP Group Referral sent to: <input type="text"/>											