Early Hearing Detection & Intervention

EHDI Arkansas

Infant Hearing Post-Discharge Initial Screen or Rescreen

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PDIS ☐ Rescreen ☐ **Screening Date:** - - 2 0 2

Reference Info Update: Is the infant's name the same as that recorded at birth? Yes ☐ No ☐

Is the Mother/Guardian/Agency's contact information the same as that recorded at birth? Yes ☐ No ☐

Child Last Name: **Date of Birth :** - - 2 0 2

Child First Name: Sex: M ☐ F ☐

Contact Information: *Please identify contact as* **Mother ☐ Guardian ☐ Agency ☐** **Adoption Pending ☐**

Last Name: Primary Phone Number:

First Name: -

Address Line 1: Alternate Phone Number:

Address Line 2: -

City: State: Zip Code:

Birth Facility Name: Birth Facility Number: - H

PCP Group Name:

Screening Information

Tester First Initial: Tester Last Name: Tester Title:

Screening Facility Name (if different from Birth Facility):

Screening Facility #: -

Basic Insurance Type: Public ☐ Private ☐ Self-Pay ☐

Risk Factors: After Immediate Neonatal Period

- ☐ Caregiver concerns about hearing, speech, language, or developmental delay
- ☐ Physical finding associated with a syndrome involving hearing loss (e.g. white forelock)
- ☐ Neurodegenerative disorder
- ☐ Post-natal infections (e.g. herpes, varicella, meningitis)
- ☐ Head trauma
- ☐ Diagnosed Cytomegalovirus (CMV)
- ☐ Chemotherapy

Screening Method and Test Results

Method of Screening: OAE ☐ AABR ☐

Left Ear: Pass ☐ Fail ☐ DNT ☐ *Please indicate reason for DNT (Did Not Test):* Equipment down ☐ Previously passed ☐ Other ☐

Right Ear: Pass ☐ Fail ☐ DNT ☐ *Please indicate reason for DNT (Did Not Test):* Equipment down ☐ Previously passed ☐ Other ☐

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:

Appointment Date: - - 2 0 2

Appointment Time: : AM ☐ PM ☐

PCP Group Referral sent to: