



Early Hearing Detection and Intervention Reporting Form

Initial hearing screening results must be reported within 6 days of the newborn's birth.

*Patient name (Last, First, MI) : M ___ F ___		Medical Record Number:	
Baby Demographics:		Risk Factors:	
<p>*Date of birth: mo <input type="text"/> day <input type="text"/> yr <input type="text"/></p> <p>*Place of Birth (if different than above): <input style="width: 100%;" type="text"/></p> <p>Gestational age: <input type="text"/> weeks</p> <p>Birth weight: <input type="text"/> grams</p> <p><input type="text"/> Time of birth</p> <p><input type="text"/> Race/Ethnicity</p>	<p><input type="checkbox"/> Assisted Ventilation</p> <p><input type="checkbox"/> Bacterial or Viral Meningitis</p> <p><input type="checkbox"/> Congenital CMV confirmed in baby</p> <p><input type="checkbox"/> Congenital Herpes confirmed in baby</p> <p><input type="checkbox"/> Congenital Rubella confirmed in baby</p> <p><input type="checkbox"/> Congenital Syphilis in baby</p> <p><input type="checkbox"/> Congenital Toxoplasmosis confirmed in baby</p> <p><input type="checkbox"/> Craniofacial anomalies</p> <p><input type="checkbox"/> ECMO</p> <p><input type="checkbox"/> Exchange transfusion for elevated bilirubin</p>	<p><input type="checkbox"/> Family hx of childhood hearing loss</p> <p><input type="checkbox"/> Head Injury</p> <p><input type="checkbox"/> Neurodegenerative Disorder</p> <p><input type="checkbox"/> NICU > 5 days</p> <p><input type="checkbox"/> Other Congenital Infection</p> <p><input type="checkbox"/> Other postnatal infection</p> <p><input type="checkbox"/> Otitis media > 3 months (middle ear infection)</p> <p><input type="checkbox"/> Ototoxic medications administered</p> <p><input type="checkbox"/> Parental concern regarding hearing status</p> <p><input type="checkbox"/> Syndrome</p>	
Mother/Guardian Information:			
<p>*Name (Last, First, MI): <input style="width: 100%;" type="text"/></p> <p>*Address: <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/></p>		<p>*Phone numbers (including area code):</p> <p><input type="text"/>-<input type="text"/>-<input type="text"/> <input type="text"/>-<input type="text"/>-<input type="text"/></p>	
*Results:		Screening Location:	
<p>Technology used:</p> <p><input type="checkbox"/> DPOAE</p> <p><input type="checkbox"/> TEOAE</p> <p><input type="checkbox"/> AABR</p>	<p>Result for Left Ear:</p> <p><input type="checkbox"/> Pass</p> <p><input type="checkbox"/> Refer</p> <p><input type="checkbox"/> Not screened (list reason) <input style="width: 100%;" type="text"/></p>	<p>Result for Right Ear:</p> <p><input type="checkbox"/> Pass</p> <p><input type="checkbox"/> Refer</p> <p><input type="checkbox"/> Not screened (list reason) <input style="width: 100%;" type="text"/></p>	<p><input type="checkbox"/> Birth Admit</p> <p>Screening date: mo <input type="text"/> day <input type="text"/> yr <input type="text"/></p> <p>OR</p> <p><input type="checkbox"/> Outpatient</p> <p>Screening date: mo <input type="text"/> day <input type="text"/> yr <input type="text"/></p>
Screen performed by: <input style="width: 100%;" type="text"/>			
(screener's name)			
*Newborn's primary care provider: <input style="width: 100%;" type="text"/>			
(name of infant's primary care provider)			