

SPEC# _____ NBHS use only

Diagnostic Hearing Evaluation Form
Department of Health, Children's Medical Services (CMS), Newborn Screening Program

*Audiology Clinic _____ *Phone Number _____ *Date of Visit _____

Demographic Information (Items with an asterisk * are required) PLEASE PRINT

*Child's Name _____	*Child's DOB _____	*Gender _____
*Street Address _____	*Multiple Birth Order _____	
*City _____ *Zip _____	*Mother's Name at Baby's Birth _____	
*County _____ *Home Phone _____	*Mother's Social Security Number _____	
*Alternate Phone #/Email _____	*Birth Hospital _____	
*Primary Language of Family _____	*Child resides with _____	
*Primary Care Physician _____	*Physician Phone _____	
*ICD9 code(s) (required for hearing loss only) _____	Physician Fax _____	

Audiological Evaluation Results:

Level 1 - Diagnostic evaluation results from this visit (Please record Pass (P) or Fail (F)):

	01 Diagnostic ABR	02 Bone Cond ABR	03 Tone Burst ABR 500	04 Tone Burst ABR 1000	05 Steady State ASSR	06 Diagnostic OAE	07 High Freq Immittance/ Tymanogram	08 BOA	09 VRA	10 Middle Ear Muscle Reflex
Right Ear	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F
Left Ear	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F

Level 2 – Type and degree of hearing loss suspected (S) or confirmed (C) during this visit:

	01 None -10-15 dB	11 Slight 16-25 dB	02 Mild 26-40 dB	03 Moderate 41-55 dB	04 Moderately Severe 56-70 dB	05 Severe 71-90 dB	06 Profound > 91 dB	07 Sensori- Neural	08 __Permanent __Temporary Conductive	09 __Permanent __Temporary Mixed	10 Auditory Dyssynchrony
Right Ear	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C
Left Ear	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C

***Referral and Follow-Up Information**

Overall Hearing Status (select one):

- ___ Apparent normal hearing in both ears at this time
- ___ Apparent middle ear dysfunction; return on _____
DD/MM/YY
- ___ Inconclusive or borderline results; return on _____
DD/MM/YY
- ___ Medical complications prevent hearing testing until age ___ months
- ___ No show/cancelled appointment scheduled for _____
DD/MM/YY
- ___ **Permanent hearing loss has been confirmed during this visit.**

Hearing risk status – Check all that apply:

- ___ Family history
- ___ PPHN
- ___ ECMO
- ___ Exchange transfusion for hyperbilirubinemia
- ___ Birth weight less than 1500 grams
- ___ NICU

Comments: (i.e. late onset loss, malformations, further referral, etc.)

FAX Form to (850) 245-4049 within 2 DAYS OF THE APPOINTMENT

*Audiologist's name: _____

*Audiologist Address: _____
Street Suite City & State ZIP

Please return this form by secure email, mail or by fax (850) 245-4049 to the FL Dept. of Health, Children's Medical Services, Newborn Screening Program, which is located at 4052 Bald Cypress Way Bin A-06 Tallahassee, Florida 32399-1707. If you need assistance completing or submitting this form, contact the Newborn Screening Program toll free at (866) 289-2037.

Children's Medical Services (CMS) - Newborn Screening Program

Instructions for completing the Diagnostic Hearing Evaluation form

Please complete and submit this form for each visit for all infants and toddlers (birth to three) WITHIN 2 DAYS OF THE APPT.:

- With CONFIRMED OR SUSPECTED permanent hearing loss; or
- With evidence of auditory neuropathy/dys-synchrony in one or both ears; or
- Who did not pass their newborn hearing screening, regardless of the evaluation results

This form is intended to collect the results of a single visit. Please record only the extent of loss noted during this visit, and use additional forms to record subsequent visits.

Release of Protected Health Information without Authorization – Children's Medical Services, a division of the Florida Department of Health, administers the Newborn Screening Program, which includes hearing and metabolic screening. Newborn screening is an activity described in its capacity as a public health authority as defined by the HIPAA Standards for Privacy of Individually Identifiable Health Information, Final Rule (Privacy Rule). Pursuant to 45 CFR 164.512(b) of the Privacy Rule, covered entities such as your organization may disclose protected health information (PHI) to public health authorities without individual authorization. Public health entities are authorized to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and for the purpose of conducting public health surveillance, public health investigations, and public health intervention. For more information, visit the Center for Disease Control and Prevention site: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm>.

Demographic Information

For the child's first visit to your facility, please complete all asterisked (*) demographic information to ensure that CMS Newborn Screening has a complete record.

Audiological Evaluation Results

Level 1 – Diagnostic evaluation results from this visit – Please indicate the type of test(s) performed and the results for each test.

Level 2 –Type and degree of hearing loss suspected (S) or confirmed (C) during this visit– Please indicate whether hearing loss is SUSPECTED (S) or CONFIRMED (C) in the appropriate box(es). **Referral to CMS Early Steps is required by Federal Law [34 CFR, § 303.303(a)(2)(i)]** for any child with a confirmed permanent hearing loss. The diagnosing audiologist must refer an infant/family to the local early intervention program as soon as possible but in no case more than seven calendar days after identification of hearing loss. **Do not wait for full threshold information.**

Referral and Follow-Up Information

Overall Hearing Status – Select a single option that best represents the hearing status determined at the close of this visit. Please use the comment section to provide further information as appropriate.

Hearing Risk Status – Please check all risk factors that apply. Family history refers to a blood relative (e.g. grandparent, parent, aunt, uncle, first cousin, siblings) with permanent hearing loss in early childhood. PPHN refers to persistent pulmonary hypertension of the newborn. ECMO refers to extracorporeal membrane oxygenation. NICU refers to the newborn intensive care unit of a hospital.

Comments – Please indicate if this is a child who passed newborn hearing screening and is later being identified with permanent hearing loss, presence of syndromes or known etiologies, if child is already receiving early intervention services, date of further confirmatory hearing testing, etcetera.

Request a Free Hearing Aid Test Kit – When requested, a free hearing aid test kit for the child will be sent to the requesting audiologist from CMS Newborn Screening Program. The "**Primary Language of the Family**" must be indicated on the form so that the appropriate instruction sheet can be included.

Please note that in order to receive a free kit:

- The child must be referred to a local Early Steps;
- CMS Newborn Screening Program must have received this form;
- The space next to "I request a hearing aid listening test kit..." must be checked; and
- The child must be under three years of age.

For more information regarding Florida's newborn screening program, referral, or diagnostic follow up services contact Newborn Screening Program at (850) 245-4201 or (866) 289-2037 or refer to www.floridanewbornscreening.com/nbscreen-hearing.html

For more information about CMS-approved audiologists or services through Early Steps for families of children with hearing loss contact Newborn Screening Program at (866)289-2037 or visit <http://www.cms-kids.com>.