



Hearing Screen Form

NEWBORN'S INFORMATION: *(Please Print)*

Newborn's Last Name

Newborn's First Name

Birth Order *(if a multiple)*

Date of Birth
MM-DD-YY

Birth Hospital

Newborn's Hospital Medical Record #

MOTHER'S INFORMATION:

Mother's Last Name

Mother's First Name

Mother's Social Security Number *(please provide entire number- not just the last 4 digits)*

HEARING SCREEN RESULTS:

Date of Hearing Screen
MM-DD-YY

Comments/Special Instructions:

Right Ear
____ Pass
____ Refer

Left Ear
____ Pass
____ Refer

Last Test Method(s) used:

Right Ear
____ OAE
____ ABR

Left Ear
____ OAE
____ ABR

Follow-up Appt.:

Date: _____

Time: _____

Location: _____

Hearing risk status – Check all that apply:

- ____ Family history (blood relative with permanent hearing loss in early childhood, e.g. grandparent, parent, aunt, uncle, first cousin, siblings)
____ PPHN
____ ECMO
____ Exchange transfusion for hyperbilirubinemia
____ Birth weight less than 1500 grams
____ NICU

Adhere facility bar code label here: (optional)

Person Completing Form

Facility

() _____ ext. _____
Phone Number

Fax to Newborn Screening Unit (850) 245-4049