

Documenting and Reporting Hearing Screenings/Evaluations



Objectives

- **Learn the difference between a hearing screening and a hearing evaluation.**
- **Become familiar with the documentation and reporting expectations for hearing screenings.**
- **Become familiar with the documentation and reporting expectations for hearing evaluations.**
- **Appreciate the importance of appropriate documentation and reporting.**



Screening vs. Evaluation

Screening

- Done by an audiologist, physician or appropriately supervised individual who has completed documented training specifically for newborn hearing screening.
- OAE/ABR
- For all babies
- Determines the need for an in-depth hearing diagnostic evaluation
- Due by 1 month of age
- Documented on specimen card or Repeat Hearing Screening form

Evaluation

- Done by an audiologist with expertise with infants, preferably a CMS-approved audiologist
- Battery of tests
- For babies who failed 2 screenings
- Rules out or confirms hearing loss
- Due by 3 months of age
- Documented on Diagnostic Hearing Evaluation form

Screening Documentation

Option #1

STATE LAB USE ONLY

Whitman 803TM Lot: 16166806K

0004109501

0004109501

FOLD FLAP OVER CASSETTE BEFORE COMPLETING DEMOGRAPHICS

IF NOT SUBMITTING BLOOD CHECK ONE REFUSED INFORMATION ONLY E-VITALS COMPLETED DECEASED ADOPTION

NEWBORN INFORMATION

NEWBORN LAST NAME _____ NEWBORN FIRST NAME _____

HOSPITAL OF BIRTH _____ NEWBORN MEDICAL RECORD NUMBER _____

DOB (MM-DD-YY) _____ TIME OF BIRTH (MM:SS) _____ WEEKS OF GESTATION _____ SELECT ALL THAT APPLY

MULTIPLE BIRTH ORDER WHITE BLACK AMERICAN INDIAN

NVCU AM HISPANIC OTHER

ASIAN/PACIFIC ISLANDER

SPECIMEN INFORMATION

FIRST REPEAT NPO ORAL FEED TPN/HYPHAL ANTIBIOTIC

LAB/DAMP/FUNDS _____ TIME IN HOUR _____ FEEDY FEED (MM:SS) _____ TIME IN HOUR _____

COLLECTED BY (LAST, FIRST, MI) _____ YRS. IN PRACTICE _____ WEIGHT AT COLLECTION (g) _____

MOTHER/LEGAL GUARDIAN INFORMATION

LAST NAME _____ FIRST NAME _____

ADDRESS (INCLUDE APARTMENT NUMBER) _____ CITY _____ ST _____ ZIP CODE _____

MOTHER'S SSN - _____ PRIMARY PHONE NUMBER _____ ALTERNATE PHONE NUMBER _____

SUBMITTER INFORMATION

SUBMITTING FACILITY/COLLECTION SITE _____ LABORATORY ID _____

RESULTS WILL BE SENT TO THIS ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

INFANT'S PHYSICIAN INFORMATION

LAST AND FIRST NAME _____ TELEPHONE NUMBER _____

STATE OF FLORIDA-DEPT. OF HEALTH-BUREAU OF LABORATORIES 1217 PEARL STREET JACKSONVILLE, FL 32202 (904) 791-1644, (800) 791-1647
 ALL SPECIMENS COLLECTED ON INFANTS <24 HRS. OF AGE / <24 HRS. ON P-PROTEIN MUST BE REPEATED AND SENT TO THE STATE LABORATORY. ALL FIELDS MUST BE FILLED OUT COMPLETELY TO AVOID DELAY.
 Infant Screening Metabolic Disorders, DH 877, MM-YY, Replaces ALL Previous Editions. Conforms to CLSI Standards.

INSURANCE INFORMATION

INSURED NAME LAST FIRST MIDDLE INITIAL _____

INSURANCE COMPANY _____

INSURANCE GROUP ID _____

INSURANCE ID NUMBER _____

PRIVATE MEDICAID MEDICAID ID NUMBER _____

SELF-PAY INSURED SSN _____ - _____ - _____

HEARING SCREENING
 DARKEN CIRCLES THAT APPLY

LEFT EAR PASS REFER OAE ABR

RIGHT EAR PASS REFER OAE ABR

HEARING RISK STATUS: (DARKEN CIRCLES THAT APPLY)

FAMILY HISTORY PPHN ECMO BIRTH WEIGHT <1500 GRAMS

HYPERBILIRUBINEMIA/HAD EXCHANGE TRANSFUSION

REASON HEARING WAS NOT SCREENED: (DARKEN ALL CIRCLES THAT APPLY)

MISSED PARENT/GUARDIAN REFUSED

NOT YET SCREENED (NICU) TRANSFER OTHER

PRESS FIRMLY. YOU ARE MAKING MULTIPLE COPIES.
 PLEASE FILL IN THIS CARD USING CAPITAL LETTERS ONLY. ILLEGIBLE HANDWRITING AND INCOMPLETE INFORMATION WILL RESULT IN DELAYS.

A Closer Look at Option #1

HEARING SCREENING DARKEN CIRCLES THAT APPLY		<input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y			
LEFT EAR	<input type="checkbox"/> PASS <input type="checkbox"/> REFER	RIGHT EAR	<input type="checkbox"/> PASS <input type="checkbox"/> REFER		
	<input type="checkbox"/> OAE <input type="checkbox"/> ABR		<input type="checkbox"/> OAE <input type="checkbox"/> ABR		
HEARING RISK STATUS: (DARKEN CIRCLES THAT APPLY)					
<input type="checkbox"/> FAMILY HISTORY	<input type="checkbox"/> PPHN	<input type="checkbox"/> ECMO	<input type="checkbox"/> BIRTH WEIGHT <1500 GRAMS		
<input type="checkbox"/> HYPERBILIRUBINEMIA/HAD EXCHANGE TRANSFUSION					
REASON HEARING WAS NOT SCREENED: (DARKEN ALL CIRCLES THAT APPLY)					
<input type="checkbox"/> MISSED	<input type="checkbox"/> PARENT/GUARDIAN REFUSED				
<input type="checkbox"/> NOT YET SCREENED (NICU) TRANSFER	<input type="checkbox"/> OTHER				

Screening Documentation

Option #2


Repeat Hearing Screen Form

NEWBORN'S INFORMATION: (Please Print)

Newborn's Last Name _____ Newborn's First Name _____
Birth Order (if 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

Right Ear	Left Ear	Comments
<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	_____
<input type="checkbox"/> Refer	<input type="checkbox"/> Refer	_____

La of Test Method(s) used:

Right Ear	Left Ear
<input type="checkbox"/> OAE	<input type="checkbox"/> OAE
<input type="checkbox"/> ABR	<input type="checkbox"/> ABR

Hearing risk factors - Check all that apply:

- Family History (blood relative w/ permanent hearing loss in early childhood, e.g., grandparent, parent, aunt, uncle, first cousin, siblings)
- PPHN
- ECMO
- Hyperbilirubinemia (phototherapy exchange transfusion)
- Low-birth weight (less than 1500 grams)
- NICU

Person Completing Form _____ Phone Number _____

Fax to Newborn Screening Unit (850) 245-4049

Newborn Screening Program
4052 Blvd. Cypress Way
Bldg #A-05
Tallahassee, FL 32399-1707

Office: (850) 289-3037
Fax: (850) 245-4049

Revised 7/2010



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A Closer Look at Option #2

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)*

A Closer Look at Option #2 Cont.

HEARING SCREEN RESULTS:

Date of Hearing Screen _____
MM-DD-YY

Right Ear

_____ Pass
_____ Refer

Left Ear

_____ Pass
_____ Refer

Comments:

Last Test Method(s) used:

Right Ear

_____ OAE
_____ ABR

Left Ear

_____ OAE
_____ ABR

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
- _____ Hyperbilirubinemia/had exchange transfusion
- _____ Low-birth weight (less than 1500 grams)
- _____ NICU

Person Completing Form

(_____) _____ ext. _____
Phone Number

What is done with the screening information?

- Copy of results are sent to primary care physician
 - Results trigger automated letters and follow-up phone calls
 - Used to measure performance and provide technical assistance
 - Data is reported for each hospital for each month on Newborn Screening's website.
 - Data is reported to the Centers for Disease Control (CDC):
 - Births
 - Screened
 - Not Screened and why
 - Passed
 - Did not pass
-

Example of Monthly Report

Children's Medical Services Hearing Report

Report Criteria:

Date of Birth Range: Jul 1 2010 - Jul 31 2010

Determination
Status
Group By Hospital

Diagnosis
Center
Report Format Current Status

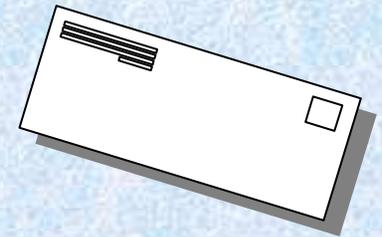
Diagnosis Type
Report Type Summary

Date Printed: 9/10/2010

Medical Rec. No:	Parent Name:	Infant Name:	Sex:	DOB:	Birth Order:	NICU:	Not Reported	Pass	Passed with Risk Factor	Referred	Hearing Loss	Not Screened	Not Screened Reason:
<i>Subtotal:</i>		<i>Patients: 4</i>					2	2	0	0	0	0	
A BIRTH CENTER													
<i>Subtotal:</i>		<i>Patients: 6</i>					4	2	0	0	0	0	
A LOVING START													
<i>Subtotal:</i>		<i>Patients: 3</i>					0	1	0	0	0	2	
A MOTHER'S NATURE HOME BIRTHS													
<i>Subtotal:</i>		<i>Patients: 1</i>					1	0	0	0	0	0	
AGAPE MIDWIFERY													
<i>Subtotal:</i>		<i>Patients: 2</i>					2	0	0	0	0	0	
ALL BRIGHT BEGINNINGS													
<i>Subtotal:</i>		<i>Patients: 6</i>					5	0	0	0	0	1	
ALL CHILDREN'S HOSPITAL													
<i>Subtotal:</i>		<i>Patients: 90</i>					0	58	3	4	0	25	
BABY LOVE BIRTH CENTER													

What happens when results are reported to the state?

- Nothing if never screened or passed.
- Letters if refer:
 - 1st letter sent 8 days from initial refer
 - 2nd letter sent 40 days from 1st letter
 - 3rd letter sent 28 days from 2nd letter
- Phone calls if refer:
 - 1st call made two weeks from initial refer
 - 2nd call made a week later if no contact
 - 3rd call made another week later if still no contact



Diagnostic Evaluation Documentation



Diagnostic Hearing Evaluation Form

Department of Health, Children's Medical Services (CMS), Newborn Screening Program
Complete this form ONLY if the infant or toddler is less than 36 months

SHINE # _____
 NBSID (see only) _____

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

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

*Child's Name _____ *Child's DOB ____/____/____ *Gender _____
 *Birth Order (if multiple birth) _____ *Birth Mother's Name _____
 *Birth Hospital _____ *Mother's Social Security Number _____
 *Street Address _____ *City _____ *Zip _____
 *Country _____ *Home Phone _____ *Child resides with _____
 *Primary Language of Family _____ *Phone # if different from mother's _____
 *Primary Care Physician _____ *Physician Phone _____
 Physician Address _____ Physician Fax _____
 *ICD9 code(s) (required for hearing loss only) _____

Audiological Evaluation Results

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

	01 Diagnostic ABR	02 Bone Conduct ABR	03 Tone Burst ABR 500	04 Tone Burst ABR 1000	05 Steady State ASSR	06 Diagnostic OAE	07 High Freq Immittance/ Tympanogram	08 BDA	09 VMA	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 - Extent of hearing loss suspected (S) or confirmed (C) during this visit:

	01 None 16-25 dB	02 Mild 26-40 dB	03 Moderate 41-55 dB	04 Moderate- Severe 56-70 dB	05 Severe 71-90 dB	06 Profound > 90 dB	07 Residual- Neural	08 Passive -Sensory Conductive	09 Passive -Sensory Mixed	10 Auditory Dysynchrony
Right Ear	__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

***Referral and Follow-Up Information - At the conclusion of this visit, overall hearing status is considered**

Apparent normal hearing in both ears at this time
 Apparent middle ear dysfunction, presence of sensorineural hearing loss is unlikely based on test history results
 Apparent middle ear dysfunction, return for more tests after ____ weeks
 Inconclusive or borderline results; return in ____ weeks to confirm
 Medical complications prevent hearing testing until age ____ months
 No show for ____ appointment(s) in ____ weeks
 Permanent / long term hearing loss has been confirmed during this visit

**Referred to your local CMS Early Steps for Part C services is required by law (14 CFR, § 301.321 d2) within 2 working days of hearing loss confirmation (not to include children with middle ear effusion without additional permanent hearing loss).
 Date of referral to CMS-Early Steps _____
 Comments: (i.e., late onset loss, malformation, further referral, etc.) _____

Material Requested from CMS Newborn Screening Program

____ Y ____ N The child uses or will use hearing aids? (If yes, a listening test kit will be sent to the audiologist.) FAX Form is # (850) 245-4849

*Audiologist's name: _____ *Audiologist's signature: _____

*Audiologist Address: _____
Street _____ Suite _____ City & State _____ ZIP _____

Please return this form by mail or by fax to the FL Dept. of Health, Children's Medical Services, Newborn Screening Program, which is located at 4052 Bald Cypress Way The A-66 Tallahassee, Florida 32399-1707. If you need assistance completing or submitting this form, contact the Newborn Screening Program toll free at (866) 289-2037 or local at (850) 245-4001. Revised 7/30/10 Hearing 0003

Completing the Diagnostic Hearing Evaluation Form

- Use most current version
- Record single visit only



 florida newborn screening Children's Medical Services	Diagnostic Hearing Evaluation Form Department of Health, Children's Medical Services (CMS), Newborn Screening Program <u>Complete this form ONLY for infants or toddlers up to age 36 months</u>	SHINE # _____ NBHS use only
*Audiology Clinic _____	*Phone Number _____	*Date of Visit _____

*(Record the date of the office visit
not date form was completed)*

Completing the Diagnostic Hearing Evaluation Form cont.



- Complete the demographic section completely

Demographic Information <i>(Items with an asterisk * are required)</i> <u>PLEASE PRINT</u>	
* Child's Name _____	* Child's DOB _____ * Gender _____
* Street Address _____	* Multiple Birth Order _____
* City _____ * Zip _____	* Birth Mother's Name _____
* County _____ * Home Phone _____	* Mother's Social Security Number _____
* Phone # <i>(if different from mother's)</i> _____	* Birth Hospital _____
* Primary Language of Family _____	* Child resides with _____
* Primary Care Physician _____	* Physician Phone _____
Physician Address _____	Physician Fax _____
_____	* ICD9 code(s) <i>(required for hearing loss only)</i> _____

Completing the Diagnostic Hearing Evaluation Form Cont.



- **Select appropriate diagnosis in the Referral and Follow-up section**

^ Referral and Follow-Up Information - At the conclusion of this visit, overall hearing status is considered	
<input type="checkbox"/> Apparent normal hearing in both ears at this time	**Referral to your local CMS Early Steps for Part C services is required by law (34 CFR, § 303.321 d.2) within 2 working days of hearing loss confirmation (not to include children with middle ear effusion without additional permanent hearing loss). Date of referral to CMS-Early Steps _____ Comments: (i.e., late onset loss, malformations, further referral, etc.) _____ _____
<input type="checkbox"/> Apparent middle ear dysfunction; return for more tests after _____ weeks	
<input type="checkbox"/> Inconclusive or borderline results; return in _____ weeks to confirm	
<input type="checkbox"/> Medical complications prevent hearing testing until age _____ months	
No show for: _____ appointment(s) in _____ weeks	
<input type="checkbox"/> Permanent/ long term hearing loss has been confirmed during this visit	

- **Form can suffice as a referral to Early Steps**
- **Include in comments section:**
 - If passed newborn hearing screening
 - Presence of syndromes or known etiologies
 - If already receiving early intervention services
 - Date of further confirmatory hearing testing

Completing the Diagnostic Hearing Evaluation Form Cont.



- Requesting Hearing Aid Listening Kits
- Completing the Audiologist name and address section

Materials Requested from CMS Newborn Screening Program

Y N The child uses or will use hearing aids? (If yes, a listening test kit will be sent to the audiologist.) FAX Form to (850) 245-4049.

*Audiologist's name: _____ *Audiologist's signature: _____

*Audiologist Address: _____

Street

Suite

City & State

ZIP

Please return this form by mail or by fax 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 or local at (850) 245-4201.

Revised 7/30/10

Hearing 0003

(This date shows when the form was last revised to ensure you have the most current form.)

Common Errors with Documenting Evaluation

- Leaving required fields blank.
- Not filling in birth order for a multiple.
- Not giving an ICD-9 code
- Faxing the clinic/office note instead of this form.
- Not taking advantage of free listening kit.
- Waiting too long to fax the form.

What is done with the evaluation information?

- Referral is faxed to Early Steps if hearing loss is confirmed
- Packet of information is sent to parent if hearing loss is confirmed
- Hearing aid listening test kit is sent to audiologist
- Primary care physician is notified if hearing loss is confirmed
- Letters/phone calls stop if hearing loss is ruled out
- Data is reported to the CDC
- Audiologist is informed of opportunity to become CMS-enrolled if not previously considered

Goals of Newborn Hearing Screening



- By 1 month of age-hearing screening completed
- By 3 months of age-hearing loss diagnosis confirmed
- By 6 months of age-early intervention services start

Become a CMS-Approved Audiologist

- Only a select group of the audiologists in Florida meet the criteria so approved individuals are recognized as a member of this elite group.
- Individuals, not offices, are CMS approved meaning this is a prestigious distinction INDIVIDUALS earn and can include on their resumes.
- This list is shared with birth hospitals, physicians and parents, increasing recognition in the community and possible referrals.
- Apply at <https://www.cmskidsproviders.com>.

Newborn Screening Program Staff

*Please contact one of the following individuals
with any questions about hearing screening reporting.*

1-866-289-2037 (toll-free)

- **Lois Taylor**, Director of Newborn Screening
lois_taylor@doh.state.fl.us
- **Pam Tempson**, EDHI Coordinator- Program Leader and Grants
pam_tempson@doh.state.fl.us
- **Rachel Eastman**, Follow-Up Coordinator – Reports and Data Collection
rachel_eastman@doh.state.fl.us
- **Shana Wetherington**, Follow-Up Coordinator – Hearing Loss and SHINE
shana_wetherington@doh.state.fl.us
- **Whitney Jones**, Senior Clerk – Daily Data Entry
whitney_jones@doh.state.fl.us
- **Stefane Fronek**, Senior Clerk – Parent Liaison
Stefane_fronek@doh.state.fl.us

For Training or Technical Assistance:



Laura Olson
Hospital Hearing Educator

(407) 592-8415

Laura_Olson@doh.state.fl.us

www.cms-kids.org

www.doh.state.fl.us/cms/nbscreen.html

Questions

