Re-screen Newborn Hearing Results Form

ALABAMA NEWBORN HEARING PROGRAM
PHONE 334.358.2082 FAX 334.206.3791

Hearing re-screen should be completed before one month of age

NEWBORN'S NAME	DATE OF BIRTH
HOSPITAL OF BIRTH	HOSPITAL ID NUMBER
MOTHER'S OR GUARDIAN'S NAME (as noted per hospital records)	HOME PHONE NUMBER
HOME ADDRESS	
PRIMARY CARE PHYSICIAN	PHYSICIAN PHONE NUMBER
ADDRESS	

BIRTH	HEARING SCREEN PERFORMED AT BIRTH FACILITY OR HOME BIRTH	Inpatient Screen Date: ______________________ Right Ear: ☐ Pass ☐ Refer ☐ Not Tested Left Ear: ☐ Pass ☐ Refer ☐ Not Tested Method: ☐ AABR ☐ OAE ☐ TEOAE ☐ DPOAE	Infants who fail initial OAE screen may have an OAE or AABR re-screen. Infants who fail initial AABR screen **must** have an AABR re-screen.
BEFORE 1 MONTH	REPEAT SCREENING RESULTS Inpatient ☐ Outpatient ☐	DATE SCREENED: __________________________ **Both ears should be tested even if only one ear did not pass the initial screen.** Right Ear: ☐ Pass ☐ Refer ☐ Not Tested Left Ear: ☐ Pass ☐ Refer ☐ Not Tested Method: ☐ AABR ☐ OAE ☐ TEOAE ☐ DPOAE *Date referred for diagnostic evaluation:_______________	RISK FACTORS FOR DELAYED HEARING LOSS: ☐ NICU admission ☐ Received ototoxic medications ☐ Transfused ☐ Other_________________________ ______________________________ If any risk factors present, refer for an audiology assessment by 24 to 30 months of age.

TEST SITE NAME	PHONE	FAX
ADDRESS		

COMMENTS/FOLLOW-UP PLAN :

____

____

____

The completed form should be returned as soon as the hearing re-screen/initial diagnostic audiological evaluation is completed. Fax to the Newborn Hearing Screening Program at 334-206-3791 .

*If refer, infant should have diagnostic testing by three months of age per the Joint Committee on Infant Hearing.