Re-screen Newborn Hearing Results Form

ALABAMA NEWBORN HEARING PROGRAM
PHONE 334.206.2944 FAX 334.206.3791

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

Alabama's Listening!
UNIVERSAL NEWBORN HEARING SCREENING

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.

Diagnostic Hearing Evaluation Form

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PHONE 334.206.2944 FAX 334.206.3791
Diagnostic testing should be completed before three months 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
ADDRESS	

TEST SITE

Audiology Provider Name	Phone	Fax
Address		

Before 3 Months	**Pediatric Diagnostic Audiology Evaluation**	**DIAGNOSTIC TEST DATE**_____ **METHOD**: ☐ABR ☐AABR ☐OAE ☐ TEOAE ☐DPOAE ☐ Normal Hearing ☐ Hearing Loss Confirmed (Please Complete Section Below)	Please select all that apply. **Both ears should be tested at each visit.**
Before 6 Months	**Enrollment in Early Intervention**	Date of Referral to EI_____ Enrollment Date_____ Medical Referral: ☐Otolaryngologist ☐Geneticist ☐Ophthalmologist ☐Pediatrician ☐ Other (specify)_____ Additional Audiology Services_____	

		dB HL	SEVERITY/TYPE	Sensorineural	Conductive*	Mixed	Unspecified	Auditory Neuropathy
___UNILATERAL LOSS	RIGHT EAR	16 to 25	Slight					
		26 to 40	Mild					
		41 to 55	Moderate					
		56 to 70	Moderately Severe					
		71 to 90	Severe					
		91+	Profound					
			Unknown Severity					
___BILATERAL LOSS	LEFT EAR	dB HL	SEVERITY/TYPE	Sensorineural	Conductive*	Mixed	Unspecified	Auditory Neuropathy
		16 to 25	Slight					
		26 to 40	Mild					
		41 to 55	Moderate					
		56 to 70	Moderately Severe					
		71 to 90	Severe					
		91 +	Profound					
			Unknown Severity					

*Includes fluid in the middle ear, ear infection, poor eustachian tube function, hole in eardrum, earwax, swimmer's ear, foreign body in the ear canal, and malformation of the outer ear, ear canal, or middle ear per the American Speech-Language Hearing Association.

COMMENTS/FOLLOW UP (please add other descriptors associated with hearing loss):

_____

_____

_____

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