NEWBORN HEARING SCREENING REPORTING FORM
INSTRUCTIONS FOR USE

Newborn Hearing Follow-up Report submission is mandated by the State of Oklahoma, Newborn Infant Hearing Screening Act§63-1-543.

PURPOSE:
This Reporting Form is to be used to report all visits to your facility by infants and children birth to three years of age. Information from these reports will be used to update the newborn hearing screening results reported at birth by the hospital and monitor that each child is receiving follow-up services as soon as possible. Annual data will be reported to the Center for Disease Control and Prevention (CDC) to determine babies "Loss to Follow-up/Loss to Documentation".

REPORTING HEARING RESULTS ON ALL INFANTS AND CHILDREN FROM YOUR FACILITY should include:

- Initial infant hearing screenings on "out of hospital births" and missed hospital screenings
- All infants that referred the initial hearing screening
- A child referred to you from other resources (parents, physicians, etc) with suspected or confirmed hearing loss
- A child being evaluated for hearing aids or cochlear implant(s)
- A child being monitored for risk factors for progressive hearing loss
- A child who exhibits any significant change in hearing status
- A child who was scheduled for follow-up from newborn screening or hearing aid fitting but missed multiple scheduled appointments and has now been lost to follow-up
- **Report <u>all</u> results even if auditory responses are within the normal limits or incomplete results**

INSTRUCTIONS FOR USE:

- Enter date of appointment, not the date you are filling out form

IDENTIFYING INFORMATION

- The child's full name, birth date, and mother's first and last name
- Mom's SS# if given
- Current address
- Name of child's hospital of birth or note if out-of-hospital birth
- Current Primary Care Physician

RESULTS:

- Complete Box 1 for screenings, complete Box 2 for diagnostic audiologic assessments
- Check correct test results for each ear. Ear specific test results are required, even if baby passed one ear on an initial screen. If baby has malformation of ear prohibiting a screening, need to refer for diagnostic ABR.
- Check all tests performed**.**
- If baby refers screening, make note of recommendations for follow-up in comments section of Box 1.
- If diagnosed hearing loss, check degree and type of loss (refer to updated ASHA guidelines for degree of loss)
- Do not mark two degrees of hearing loss. If the hearing loss crosses two levels, check the degree that encompasses the majority of the frequencies
- Include date of amplification and check type of amplification device
- Check all other referrals made
- If enrolled or referred to early intervention, note location if known
- Note any known risk factors/family history

Please return or fax the **completed form**, or **audiology report** to: Newborn Hearing Screening Program
Oklahoma State Department of Health
123 Robert S. Kerr Ave
Oklahoma City, OK 73102
Fax (405) 900-7554* as of Dec 2020

Hearing Results
Newborn Screening Program
Oklahoma State Department of Health
123 Robert S. Kerr
Oklahoma City, OK 73102
405-426-8220, Option 1 (as of Dec 2020)

Dear Clinician: *If the infant's parent/guardian did not bring a similar form that includes the infant's identifying information, use this form to report hearing screening or audiologic diagnostic results to the newborn screening program. Please return the completed form to the address above or FAX it to 405-900-7554.*

Infant's last name: **Infant's first name:** **DOB:**

Mom's last name: **Mom's first name:** **Mom's SS#:**

Address: **City:** **State:** **Zip:**

Birth Facility: **Primary Care Physician (PCP) Name :**

To the clinician evaluating hearing: *Complete Box 1 if you are screening hearing; complete Box 2 if you are providing a diagnostic audiologic assessment.*

Box 1: Hearing Screening Results

Screening Date:

Results:

Right Ear: □ Pass □ Refer **Left Ear**: □ Pass □ Refer **Screen Method**: □ ABR □ OAE □ other_____

Early Intervention: □ Referred □ Already enrolled Location: _____

Comments:

Person screening: _____ **Title:**_____ **Phone:**_____

Box 2: Diagnostic Audiologic Assessment Results

Assessment Date: **Seen previously?** □ Yes □ No **If Yes, Date:**

Results:

Right Ear: □ Normal □ Slight Loss □ Mild Loss □ Moderate Loss □ Severe Loss □ Profound Loss □ Inconclusive
□ Sensorineural □ Conductive □ Mixed □ ANSD □ Undetermined

Left Ear: □ Normal □ Slight Loss □ Mild Loss □ Moderate Loss □ Severe Loss □ Profound Loss □ Inconclusive
□ Sensorineural □ Conductive □ Mixed □ ANSD □ Undetermined

Assessments used: (Check all that apply) □ ABR □ Bone ABR □ ASSR □ TEOAE □ DPOAE □ BOA □ VRA
□ Pure Tone □ Tympanometry □ other_____

Early Intervention: □ Referred □ Already enrolled Location: _____

Amplification: Date _____ Type: □ Hearing Aid □ Cochlear Implant □ other_____

Referrals/Resources: □ PCP □ ENT □ Genetics □ Ophthalmology □ other_____

Risk Factors/Family History:_____

Recommendations/Comments:

Audiologist: _____ **Phone** _____