Physician Form to Fax Results of Outpatient Hearing Screen or Diagnostic Audiological Evaluation to State Newborn Hearing Screening Program

Date: ______________________

Dr: ______________________ Practice: ______________________

Phone: ______________________ Fax: ______________________

RE: The following child in your care DID NOT PASS OR DID NOT RECEIVE the Newborn Hearing Screen:

Child: ______________________ DOB: ______________________

Parent: ______________________ Hospital: ______________________

You may have already referred this child for an outpatient hospital hearing screen (if available), or to a local audiologist (see list) for a diagnostic audiological evaluation. Please complete the appropriate section(s) below:

Outpatient Hearing Screen:
☐ Outpatient Hearing Screen Scheduled as follows:
  Date: ______________________ Location: ______________________
  Phone: ______________________

☐ Outpatient Hearing Screen Completed as follows:
  Date: ______________________ Location: ______________________
  Phone: ______________________
  Results: Right Ear: ☐ Pass ☐ Refer
  Left Ear: ☐ Pass ☐ Refer

Diagnostic Hearing Evaluation:
☐ Diagnostic Hearing Evaluation Scheduled as follows:
  Date: ______________________ Location: ______________________
  Phone: ______________________

Diagnostic Hearing Evaluation Completed on: ______________________ at: ______________________

Results of Diagnostic Hearing Evaluation (Complete All that Apply OR Fax Copy of Audiological Report):

Diagnostic ABR: 500 1000 2000 4000 Hz

Right ear threshold: _____ dBnHL _____ _____ _____
Left ear threshold: _____ dBnHL _____ _____ _____

Degree of hearing loss: Hearing Loss: Type of Hearing Loss:
☐ Normal ☐ Unilateral ☐ Conductive/Fluctuating conductive
☐ Mild (16-35 dbHL) ☐ Bilateral ☐ Sensorineural
☐ Moderate (36-50 dbHL) ☐ Mixed ☐ Mixed
☐ Moderate/Severe (51-70 dbHL) ☐ Auditory Neuropathy/Dyssynchrony
☐ Severe (71-90 dbHL)
☐ Profound (91 or greater dbHL)

Comments: ______________________

Please Complete Within 48 hours of Receipt & Fax Back to Newborn Hearing Screening Program at 505-476-8817. If you have questions or need additional information, call 1-877-890-4692.