NEW MEXICO
Department of Health
Public Health Division

MICHELLE LUJAN GRISHAM
Governor

PATRICK M. ALLEN
Cabinet Secretary

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:
☐ Normal
☐ Mild (16- 35 dbHL)
☐ Moderate (36-50 dbHL)
☐ Moderate/Severe (51-70 dbHL)
☐ Severe (71-90 dbHL)
☐ Profound (91 or greater dbHL)

Hearing Loss:
☐ Unilateral
☐ Bilateral

Type of Hearing Loss:
☐ Conductive/Fluctuating conductive
☐ Sensorineural
☐ Mixed
☐ Auditory Neuropathy/Dyssynchrony

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.