



**NEWBORN HEARING SCREENING REPORT AND REFERRAL FORM**  
 EARLY HEARING DETECTION AND INTERVENTION PROGRAM  
 Children's Medical Services, Family Health Bureau  
*Birth Hospital/Birth Center is required to report hearing screen results for every birth.*

Date Faxed / Mailed: \_\_\_\_\_ Name of Person Completing Form: \_\_\_\_\_

Phone Number of Person Completing Referral Form: \_\_\_\_\_

Medical Record #: \_\_\_\_\_ Birth Center/Hospital: \_\_\_\_\_

Hospital Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Baby's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Baby's Gender: \_\_\_ Male \_\_\_ Female      Baby's Date of Birth: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**Doctor Who Will Follow Baby Post Discharge:**

Name: \_\_\_\_\_ Practice: \_\_\_\_\_

Address, City, State: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Parent Contact Information:**

Mother's Name: \_\_\_\_\_ Mother's DOB: \_\_\_\_\_

Mother's Primary Language: \_\_\_\_\_ Mother's Email Address: \_\_\_\_\_

\*Mailing Address: \_\_\_\_\_

*\*Please include apartment #, trailer space #, etc.*

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Message Phone Number: \_\_\_\_\_

**Baby Has Risk Factor(s) for Hearing Loss:** \_\_\_ Ototoxic Drugs \_\_\_ Prematurity \_\_\_ NICU  
 \_\_\_ Atresia/Microtia \_\_\_ Craniofacial Anomalies \_\_\_ Family History of Hearing Loss \_\_\_ Syndrome

**Baby DOES NOT Have Any KNOWN Risk Factor(s) for Hearing Loss:** \_\_\_\_\_

**Hearing Screen Results:**

Date(s) of Screen(s): \_\_\_\_\_ **Right Ear:** PASS / REFER / INCOMPLETE    **Left Ear:** PASS / REFER / INCOMPLETE  
 \_\_\_\_\_ **Right Ear:** PASS / REFER / INCOMPLETE    **Left Ear:** PASS / REFER / INCOMPLETE  
 \_\_\_\_\_ **Right Ear:** PASS / REFER / INCOMPLETE    **Left Ear:** PASS / REFER / INCOMPLETE

***Baby must pass screen in both ears during the same screen for it to be a pass.***

Total # of Screens: \_\_\_\_\_ (Screen No More than 2 times unless 2<sup>nd</sup> screen was incomplete or passed in different ears in first 2 screens)

\_\_\_\_\_ **Discharged Without Screen Date:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

\_\_\_\_\_ **Transferred Date:** \_\_\_\_\_ **Transferred to:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

Mother's signature for release: \_\_\_\_\_ Date: \_\_\_\_\_

**All Fields on Form Must Be Completed. Send Completed Form to DOH Newborn Hearing Screening Program:**

**Securely Email to:** [Newborn.Hearing@state.nm.us](mailto:Newborn.Hearing@state.nm.us) or **Fax to:** (505) 827-5995 or (505) 476-8896, or

Mail to: DOH/PHD/CMS Newborn Hearing Screening Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505

Questions call: (505) 476-8868 or Toll Free at 1 (877) 890-4692

*Form version November 2021*