



Hearing Screening Reporting Form

After conducting a newborn hearing screening, complete and fax this form to the Oregon EHDI Program at **971-673-0251** for all newborns that facility staff **cannot** view and update in the OVERS or EHDI-IS databases.

Patient Information

Child's Name (Last, First): _____ Date of Birth: _____
 Sex: Female Male Other: _____
 Address, City, State: _____
 Mother/Parent Name (Last, First): _____ Phone: _____
 Birth Facility Name: _____
 Birth Location: Home Birth Hospital Birthing Center Primary Language: _____

Risk Factors (select all that apply)

- Family history of permanent hearing loss present at birth or starting in childhood
- Admission to NICU for more than 5 days
- In-utero infection (e.g., CMV, Zika, herpes, toxoplasmosis)
- Culture-positive postnatal infection (e.g., meningitis, herpes)
- Craniofacial anomaly (e.g., ear pit/tag, cleft lip/palate, aural microtia/atresia)
- Syndrome associated w/ hearing loss (e.g., CHARGE, Waardenburg, Trisomy 21, Long QT)
- Neurodegenerative disorder (e.g., Hunter Syndrome, Charcot-Marie-Tooth Syndrome)
- None

Screening Information

1	Has child had prior hearing screening(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, facility: _____	
2	Date of Screening: _____	Select One: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
	Screener Name: _____	Screening Equipment: <input type="checkbox"/> OAE <input type="checkbox"/> A-ABR
	Screening Facility: _____	

Screening Results (both ears must be tested every time)

	Left Ear	Right Ear
3	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass

If baby did not pass or if screening was not performed, complete ALL of Section 4

4	<input type="checkbox"/> Did not pass <input type="checkbox"/> Not performed (select reason): <input type="checkbox"/> equipment failure <input type="checkbox"/> physical condition of the ear <input type="checkbox"/> refused (<u>obtain signed waiver</u>) <input type="checkbox"/> no show/cancel or missed <input type="checkbox"/> deceased	<input type="checkbox"/> Did not pass <input type="checkbox"/> Not performed (select reason): <input type="checkbox"/> equipment failure <input type="checkbox"/> physical condition of the ear <input type="checkbox"/> refused (<u>obtain signed waiver</u>) <input type="checkbox"/> no show/cancel or missed <input type="checkbox"/> deceased
	<input type="checkbox"/> Scheduled for rescreen (Date or Timeframe): _____	
	<input type="checkbox"/> Referred to audiology (Facility Name): _____ Primary Care Provider or Midwife: _____	

Notes