Oregon Health Authority

SCREENING REPORT FORM

Early Hearing Detection and Intervention (EHDI) Program

For newborn hearing screenings performed on babies that you cannot view in the OVERS system, please fax the following information to the EHDI Program at **971-673-0251**. Record all other newborn hearing screenings in the OVERS Hearing Screening Module. *Complete this information with family present.*

Child Full Name:	**Parent/Guardian Full Name(s):**
Child Sex: ☐ Female ☐ Male ☐ ____________ **Child Date of Birth:** ______________ **Birth Facility Name & City:** *or* ☐ **Home Birth** ☐ **Other:**	**Family Mailing Address:** **Phone Number:** ☐ Text ☐ Voice

Please select any risk factors for hearing loss that apply to this child:

- ☐ 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

	PLEASE COMPLETE ALL FIELDS OF SCREENING INFORMATION BELOW	
1	**Has child had prior hearing screening(s)?** ☐ No ☐ Yes* If yes, facility: ________________ ** If child screened with A-ABR, do not rescreen with OAE. See EHDI Protocol at healthoregon.org/ehdi.*	
2	**Date of Screening:**	**Select One:** ☐ Inpatient ☐ Outpatient
2	**Screener Name:**	**Screening Equipment:** ☐ OAE ☐ AABR
2	**Screening Facility:**	
	Screening Results (both ears must be tested every time)	
3	**Left Ear**	**Right Ear**
3	☐ Pass	☐ Pass
	If baby did not pass or if screening was not performed, complete ALL of Section 4	
4	**Left Ear**	**Right Ear**
4	☐ Did not pass ☐ Not performed** (select reason): ☐ equipment failure ☐ physical condition of the ear ☐ refused (obtain signed waiver) ☐ no show/cancel or missed ☐ deceased	☐ Did not pass** ☐ Not performed** (select reason): ☐ equipment failure ☐ physical condition of the ear ☐ refused (obtain signed waiver) ☐ no show/cancel or missed ☐ deceased
4	☐ **Scheduled for rescreen:** (date or timeframe) ______________________________ ☐ **Referred to audiology:** (facility name) ____________________________________ **Primary Care Provider Name/Practice:** _______________________________________ **Additional contact:** (please identify grandparent, friend, neighbor, etc. and give phone number, email) ____ **Primary language if not English:** ____	