**NEWBORN HEARING SCREENING REPORT AND REFERRAL FORM**
EARLY HEARING DETECTION AND INTERVENTION PROGRAM
Children's Medical Services, Family Health Bureau
***Midwife/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 #:_____ Midwife:_____ 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 Factors for Hearing Loss**:___Ototoxic Drugs____Prematurity____NICU_____Atresia/Microtia
_____Craniofacial Anomalies____Family History of Hearing Loss____Syndrome

Baby **DOES NOT** Have Any **KNOWN** Risk Factors for Hearing Loss:_____

Complete If Baby's **Hearing WAS Screened** by **Midwife:**

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 2nd screen was incomplete or pass in different ears in first 2 screens)

Complete If Baby's **Hearing WAS NOT Screened** by **Midwife:**

_____Unable to screen baby's hearing. Reason: _____.

Referred baby for a hearing screen 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 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 December 2021*