Original to CMS Pink Copy to Parent Yellow Copy to Medical Home

Date Copy Faxed / Mailed to CMS:_____ Name of Midwife Completing Form: _____

MIDWIFE REPORTING FORM

Midwife Name or Name of Center: _____

Baby's Last Name: _____ First Name: _____

Baby's Gender: ___Male ____Female Baby's Date of Birth: _____

Baby's Hearing Was Screened By Midwife or Center: _____Yes _____No

If Hearing Was Screened:

Date(s) of Screen(s): _____ Right Ear: PASS / REFER Left Ear: PASS / REFER

_____ Right Ear: PASS / REFER Left Ear: PASS / REFER

_____ Right Ear: PASS / REFER Left Ear: PASS / REFER

Total # of Screens: _____**(Screen NO More than 3 times)**

Doctor Who Will Follow Baby:

Name: _____ Practice: _____

Address, City, State: _____

Phone Number: _____

Parent Contact Information:

Mother's Name: _____Mother's DOB:_____

Mother's Primary Language: _____

Mailing Address _____

Please include apartment #, trailer space #, etc.

City _____ State _____ Zip Code _____

Phone Number: _____ Message Phone Number: _____

Email Address: _____

Mother's signature for release: _____Date: _____

Comments: _____

_____

_____

All Fields on Form Must Be Complete. Fax or Mail to Children's Medical Services within 24 hours of baby's birth as follows:

Fax: (505) 827-5995 or (505) 476-8896
Mail:
Department of Health, Children's Medical Services, Newborn Hearing Screening Program
1190 S. St. Francis Drive, Santa Fe, NM 87505

Questions for Newborn Hearing Screening Program: Call (505) 476-8852 or Toll Free at 1 (877) 890-4692