Physician Form to Fax Results of Outpatient Hearing Screen or Diagnostic Audiological Evaluation to State Newborn Hearing Screening Program

Date: _____

Dr: _____ Practice: _____

Phone: _____ Fax: _____

RE: The following child in your care ***DID NOT PASS*** OR ***DID NOT RECEIVE*** the Newborn Hearing Screen:

Child: _____ DOB: _____

Parent: _____ Hospital: _____

You may have already referred this child for an outpatient hospital hearing screen (if available), or to a local audiologist (see list) for a diagnostic audiological evaluation. Please complete the appropriate section(s) below:

Outpatient Hearing Screen:

☐ Outpatient Hearing Screen Scheduled as follows:
Date: Location:
Phone:

☐ Outpatient Hearing Screen Completed as follows:
Date: Location:
Phone:
Results: Right Ear: ☐Pass ☐Refer
Left Ear: ☐Pass ☐Refer

Diagnostic Hearing Evaluation:

☐ Diagnostic Hearing Evaluation Scheduled as follows:
Date: Location:
Phone:

Diagnostic Hearing Evaluation Completed on:_____ at:_____

Results of Diagnostic Hearing Evaluation *(Complete All that Apply **OR Fax Copy of Audiological Report**)*:

Diagnostic ABR:		**500**	**1000**	**2000**	**4000 Hz**
Right ear threshold:	_____ dBnHL	____	____	____	____
Left ear threshold:	_____ dBnHL	____	____	____	____

Degree of hearing loss:
☐ Normal
☐ Mild (16- 35 dbHL)
☐ Moderate (36-50 dbHL)
☐ Moderate/Severe (51-70 dbHL)
☐ Severe (71-90 dbHL)
☐ Profound (91 or greater dbHL)

Hearing Loss:
☐ Unilateral
☐ Bilateral

Type of Hearing Loss:
☐ Conductive/Fluctuating conductive
☐ Sensorineural
☐ Mixed
☐ Auditory Neuropathy/Dyssynchrony

Comments:_____

_____

Please Complete Within 48 hours of Receipt & Fax Back to Newborn Hearing Screening Program at 505-827-5995. If you have questions or need additional information, call 1-877-890-4692.