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):*

<table>
<thead>
<tr>
<th>Diagnostic ABR</th>
<th>500</th>
<th>1000</th>
<th>2000</th>
<th>4000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right ear threshold:</td>
<td>_____ dBnHL</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>Left ear threshold:</td>
<td>_____ dBnHL</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

**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.