Outpatient Hearing Screening Form
Early Hearing Detection and Intervention Program

FAX (517) 335-8036 (Send hearing screen card to MDCH)

Newborn Information

Newborn's Name: ____Date of Birth: _____________________

Hospital of Birth: ____

Inpatient Screen Date: ______/ **Right Ear**: Pass Refer **Left Ear:** Pass Refer **Method:** AABR OAE

Parent/Guardian Contact Information

Mother's Name: ____

Address: ____

Phone #: (________)_______________________ Alternate #: (________)_________________________

*****Alternate Contact (Friend/relative/case worker/adoption agency)******

Name: ____

Address: ____

Phone #: (________)_______________________ Alternate #: (________)_________________________

Referral Information

! Referral to primary care physician for follow-up: Name: ____

Phone #: (________)_____________________ Date Schedule: __________________________________

! Referral for outpatient re-screening? Site name: ____

Phone #: (________)_____________________ Date Schedule: __________________________________

! Referral for diagnostic audiological assessment?: Site name: ______________________________________

Phone #: (________)_____________________ Date Schedule: __________________________________

! Other: (Early On, Health Department/CSHCS) County: ______________________________________

Outpatient Screen Results

Date: ______________________

Type of Screen: ( ) AABR () DPOAE () TEOAE () ABR

Results: RE () Pass () Fail/Refer
LE () Pass () Fail/Refer

Risk factor(s) for hearing loss? () Yes () No () Unknown
Referral to audiological diagnostic? () Yes () No
Date audiological evaluation scheduled: ________________

Rescreen Site Name:

Parental/Guardian Permission

I give my permission to release referral results to my primary care physician, the Michigan Department of Community Health (MDCH) Early Hearing Detection and Intervention (EHDI) Program, the Michigan Department of Education (MDE), *Early On* ©Michigan, and Children's Special Health Care Services. MDCH/EHDI and *Early On* ©Michigan also have my permission to assist with coordination of follow-up on behalf of my child. Diagnostic, follow-up, and intervention information can be sent to MDCH from participating agencies. Information will not be shared with unauthorized people or agencies not involved in hearing screening follow-up and/or intervention in conjunction with the MDCH Program.

Signature of Parent/Guardian: ____________________________________Date: ___________________

Updated 7/8/05