**** NOTE: Hearing results should be submitted on the Newborn Screening Filter Card OR pink form Use this form ONLY if these were not used & fax to Newborn Screening Program at 615-532-8555****

Tennessee Department of Health
Newborn Screening Follow Up Program
1st Floor, R.S. Gass Building
630 Hart Lane, Nashville, Tennessee 37243
Phone (855) 202-1357 Fax (615) 532-8555

Hearing Screen Only Form

(See note above – Filter Card or Pink Form should be used first if possible)

Child's Last Name **First Name** **Middle Name** **Gender** **(Twin: A or B)** **Date of Birth**

Birth Mother's Last Name **First Name** **Maiden Name** **State Lab TDH#**

Address **City** **State/Zip** **Phone**

Primary Care Provider **Phone**

Birth Hospital Name: _____ City/State: _____

If this infant was TRANSFERRED, list hospital: _____

Person filling out form (print name): _____ Phone: _____

Facility/Provider Name: _____ City: _____

RESULTS – INITIAL SCREEN:

Date of Initial Hearing Screen: _____/_____/_____ **Method:** ☐ABR/AABR ☐OAE

Results: R: ☐Pass ☐Refer **L:** ☐Pass ☐Refer **Risk Factors:** Mark in box at bottom of page

IF INFANT DID NOT PASS INITIAL SCREEN AND FURTHER EVALUATION (RESCREEN OR DIAGNOSTIC) WAS COMPLETED:

Test Completed by: ☐Hospital ☐PCP ☐Audiologist ☐ENT/Otolary ☐Other_____

Date of Follow-up Hearing Screen: _____/_____/_____

Type of Evaluation: ☐ABR/AABR ☐OAE ☐Tymp/Reflex ☐ASSR ☐Behavioral

Results: R: ☐Pass ☐Refer **L:** ☐Pass ☐Refer

IF THIS INFANT WAS REFERRED TO: ☐Audiologist ☐ ENT ☐Other_____

Name: _____ Phone: _____ Appointment on: ____/____/____

Comments/Reason: _____

Risk Factors: (see below, check all that apply)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

1. NICU > 5 days
2. Syndrome associated with progressive or late onset HL
3. Family history of permanent childhood hearing loss
4. Craniofacial anomalies including those that involve the pinna, ear canal, ear tags, ear pits or temporal bone anomalies
5. In-utero infections such as CMV, Herpes, Rubella, Syphilis, & Toxoplasmosis
6. ECMO

A. Chemotherapy
B. Assisted ventilation
C. Ototoxic medications or loop diuretics
D. Hyperbilirubinemia requiring exchange transfusion
E. Physical findings such as white forelock associated with syndromes known to include SNHL or permanent conductive HL
F. Postnatal culture-positive infections associated with SNHL, including confirmed bacterial and viral (especially Herpes & Varicella), meningitis

Please COMPLETELY FILL OUT THIS FORM and fax to the Newborn Screening Program at 615-532-8555