ND Early Hearing Detection & Intervention

Hearing Screen Reporting Form

fax completed form to 701.858.3483

www.ndcpd.org/ehdi

Please enter contact information of the *PERSON FILLING OUT FORM*

Name: _____ Agency: _____

Phone: _____ E-mail: _____

Patient Information

Child's name (Last, First, MI):_____

Date of birth: _____ **Gender:** □ Male □ Female

Place of Birth: □ Home □ Hospital (name):_____

Primary Care Physician: _____

Risk Factors: □ Ototoxis meds □ NICU>5days □ Cranio-anomaly □ Other: _____

Mother/Guardian Information

Mother's Name: _____ **Father's Name:** _____

Address, City, State, Zipcode: _____ **Phone:** _____

Hearing Screen Results

Screening Location: □ Initial Birth Screen □ Outpatient Follow-up Screen

Date of Screening: _____

Device Type: (Accuscreen, AuDX, Euroscreen, Algo, etc.):_____

Technology used:	**Left Ear Results:**	**Right Ear Results:**
□ DPOAE	□ Pass	□ Pass
□ TOAE	□ Refer	□ Refer
□ AABR	□ Not Screened (list reason)	□ Not Screened (list reason)
	_____	_____

Screen performed by: _____

Screener has made Early Intervention/Pimary Care Physician referral(s) to: □ No referral made

□ Right Track □ Parent Infant Program □ Infant Development (Part C) □ Primary Care Physician

Additional Information/Notes