ALABAMA NEWBORN HEARING RE-SCREENING RESULTS
PHONE 334.206.2944 FAX 334.206.3791
USE THIS SIDE FOR FOLLOW-UP RE-SCREEN
BOTH EARS MUST BE TESTED

NEWBORN'S NAME	DATE OF BIRTH
HOSPITAL OF BIRTH	MEDICAL ID #
MOTHER'S NAME	PHONE
ADDRESS	
PRIMARY CARE PHYSICIAN	PHONE
ADDRESS	

BIRTH	HEARING SCREEN PERFORMED AT BIRTH FACILITY	Inpatient Screen Date___________________ Right Ear: ☐Pass ☐ Refer ☐ Not Tested Left Ear: ☐ Pass ☐ Refer ☐Not Tested Method: ☐ AABR ☐ OAE ☐ TEOAE ☐DPOAE	Infants who fail initial OAE screen can have an OAE or AABR re-screen. Infants who fail initial AABR screen must have an AABR re-screen.
BEFORE 1 MONTH	REPEAT SCREENING RESULTS Inpatient ☐ Outpatient ☐	DATE SCREENED: Right Ear: ☐Pass ☐ Refer ☐ Not Tested Left Ear: ☐ Pass ☐ Refer ☐Not Tested Method: ☐ AABR ☐ OAE ☐ TEOAE ☐DPOAE	RISK FACTORS FOR DELAYED HEARING LOSS ☐ NICU >48 hrs ☐ Received ototoxic medications ☐ Transfused ☐ Other____________________________ ________________________________ If any present refer for audiology evaluation at least once prior to 30 months of age.

TEST SITE NAME	PHONE	FAX
ADDRESS		

COMMENTS/FOLLOW-UP
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The completed form should be returned as soon as the hearing re-screen/initial diagnostic audiological evaluation is completed, but no later than 4 weeks from the date of the referral. Fax to the Newborn Hearing Screening Program at 334-206-3791 .

ALABAMA NEWBORN HEARING RE-SCREENING RESULTS
PHONE 334.206.2944 FAX 334.206.3791
USE THIS SIDE FOR DIAGNOSTIC TESTING ONLY
BOTH EARS MUST BE TESTED

NEWBORN'S NAME	DATE OF BIRTH
HOSPITAL OF BIRTH	MEDICAL ID #
MOTHER'S NAME	PHONE
ADDRESS	

TEST SITE

Name	Phone	Fax
Address		

Before 3 Months	**Pediatric Diagnostic Audiology Evaluation**	**DIAGNOSTIC TEST DATE**________________ **METHOD:** ☐ABR ☐AABR ☐OAE ☐ TEOAE ☐DPOAE ☐ Normal Hearing ☐ Hearing Loss Confirmed (Please Complete Section Below)
Before 6 Months	**Enrollment in Early Intervention**	Date of Referral to EI_______________________ Enrollment Date___________________ Medical Referral: ☐Otolaryngologist ☐Geneticist ☐Ophthalmologist ☐Pediatrician ☐ Other (specify)____ Additional Audiology Services____

___UNILATERAL LOSS

RIGHT EAR dB HL	SEVERITY/TYPE	Sensorineural	Conductive	Mixed	Unknown	Auditory Neuropathy
16 to 25	Slight					
26 to 40	Mild					
41 to 55	Moderate					
56 to 70	Moderately Severe					
71 to 90	Severe					
91+	Profound					
	Unknown Severity					

___BILATERAL LOSS

LEFT EAR dB HL	SEVERITY/TYPE	Sensorineural	Conductive	Mixed	Unknown	Auditory Neuropathy
16 to 25	Slight					
26 to 40	Mild					
41 to 55	Moderate					
56 to 70	Moderately Severe					
71 to 90	Severe					
91 +	Profound					
	Unknown Severity					

COMMENTS/FOLLOW UP

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The completed form should be returned as soon as the hearing re-screen/initial diagnostic audiological evaluation is completed, but no later than 4 weeks from the date of the referral. Fax to the Newborn Hearing Screening Program at 334-206-3791.