ALABAMA NEWBORN HEARING RE-SCREENING RESULTS
PHONE 334.206.2944 FAX 334.206.3791

USE THIS SIDE FOR FOLLOW-UP RE-SCREEN - SIDE A

BOTH EARS MUST BE TESTED

Alabama's Listening!
UNIVERSAL NEWBORN HEARING SCREENING

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

_____

_____

_____

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 - SIDE B

BOTH EARS MUST BE TESTED

Alabama's Listening!
UNIVERSAL NEWBORN HEARING SCREENING

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_____	

		dB HL	**SEVERITY/TYPE**	**Sensorineural**	**Conductive**	**Mixed**	**Unknown**	**Auditory Neuropathy**
___UNILATERAL LOSS	RIGHT EAR	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					
		dB HL	**SEVERITY/TYPE**	**Sensorineural**	**Conductive**	**Mixed**	**Unknown**	**Auditory Neuropathy**
___BILATERAL LOSS	LEFT EAR	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

_____

_____

_____

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.