DEPARTMENT OF HEALTH

Hearing Screening and Pulse Oximetry (CCHD) Results Report Form

Infant's Name:

Infant's DOB:

Birthing Parent's Name:

Screening Provider/Location:

Primary Care Provider (name/location):

Hearing Screening Results

Date of Screening:

Screening Provider/Location:

Right Ear: ☐ Pass ☐ Refer

Left Ear: ☐ Pass ☐ Refer

Hearing Rescreening Results

Date of Rescreening:

Rescreening Provider/Location:

Right Ear: ☐ Pass ☐ Refer

Left Ear: ☐ Pass ☐ Refer

If one or both ears do not pass the **rescreen**, please indicate scheduled diagnostic appointment information (date and location) in the comments section.

Pulse Oximetry (CCHD) Screening Results:

Date of Screening:

Screening Provider / Location:

1st Screen Result		2nd Screen Result		3rd Screen Result	
Heart Rate		Heart Rate		Heart Rate	
Time of Screen:		Time of Screen:		Time of Screen:	
Right hand (Sat Value):		Right hand (Sat Value):		Right hand (Sat Value):	
Foot (Sat Value):		Foot (Sat Value):		Foot (Sat Value):	

* The Minnesota Department of Health does not require the baby's heart rate.

Additional Comments:

FAX, email, or mail this result report to the Minnesota Department of Health within 48 hours of screening.

Send or fax completed form to:
Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St. Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 215- 6285
Email: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening