



NEWBORN HEARING SCREENING AUDIOLOGY FOLLOW-UP REPORT FORM

PATIENT INFORMATION

Child's name (last, first): Date of birth: Sex at birth: M ☐ F ☐

Address, City, State:

Mother's name (last, first): Mother's phone:

Caregiver's name/relationship/phone (if different): Language used in home:

Primary Clinic Name, City:

If not MN birth, include birth hospital or home birth city/state:

TEST RESULTS **IMPORTANT: Test both ears and do not delay complete audiological diagnosis due to middle ear fluid**

Test date: Audiologist: Clinic name, City:

✓ ALL THAT APPLY		RIGHT EAR		LEFT EAR		
SCREENING OR DIAGNOSTIC RESULTS	☐ AABR (screening)	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	
	☐ DPOAE	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	
	☐ TEOAE	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass	☐ Refer ☐ Inconclusive ☐ Not Done	
	Tympanometry					
	☐ 226 Hz ☐ 1000 Hz	☐ Peak ☐ Rounded ☐ No Peak ☐ Lg. Volume		☐ Peak ☐ Rounded ☐ No Peak ☐ Lg. Volume		
	☐ Acoustic Reflex	☐ Normal ☐ Elevated ☐ Absent		☐ Normal ☐ Elevated ☐ Absent		
	DIAGNOSIS		Degree	Type	Degree	Type
			☐ Normal	☐ Normal	☐ Normal	☐ Normal
			☐ Slight	☐ Sensorineural	☐ Slight	☐ Sensorineural
			☐ Mild	☐ Permanent Conductive	☐ Mild	☐ Permanent Conductive
☐ Moderate			☐ Transient Conductive	☐ Moderate	☐ Transient Conductive	
☐ Moderate Severe			☐ Mixed	☐ Moderate Severe	☐ Mixed	
☐ Severe			☐ ANSD	☐ Severe	☐ ANSD	
☐ Profound			☐ Undetermined	☐ Profound	☐ Undetermined	

REFERRALS AND APPOINTMENTS

✓ ALL THAT APPLY IF KNOWN

☐ Audiology Appointment date:	☐ Amplification ☐ <u>Loaner</u> Fit date:
☐ Otolaryngology Appointment date:	☐ Genetic evaluation Appointment date:
☐ <u>Help Me Grow</u> Referral date:	☐ Ophthalmology Appointment date:
☐ <u>Parent Support</u> Referral date:	Other (specify):

NOTES/APPOINTMENT CHANGE