



IDAHO SOUND BEGINNINGS (ISB)

Early Hearing Detection and Intervention
Department of Health and Welfare, Infant Toddler Program

FAX TO (208) 332-7331

Within 5 days

Newborn
Hearing
Screening
Referral Form

Complete Form for All: **Refers** **Risks** **Transfers*** **Missed** or **Incomplete**

Birth Hospital: _____

(*Transfers only) **Receiving Hospital:** _____ [Please Press Firmly]

Within **5 days** of screening or discharge— Distribute copies to: Audiologist - White ISB - Gold Hospital - Pink Parent - Green Physician - Yellow

Send to: Idaho Sound Beginnings-EHDI, PO Box 83720, Boise, ID 83720 or **Fax: (208) 332-7331**

1. BABY'S INFORMATION:

Baby's Med Record #: _____

Baby's Name: _____
Last First

DOB: ____/____/____ **Gender:** M F

Nursery: Well Baby NICU/Special Care

Baby's Primary Physician/Clinic: _____

Mother's name: _____

2. CONTACT INFORMATION:

Parent/Guardian: _____
Last First

Address: _____

City: _____ **State:** _____ **Zip:** _____

Main Phone: _____ **Text?** _____

Alternate Phone/Contact: _____

Email/other contact: _____

3. HEARING SCREEN RESULTS:

First Screen: **R** Pass Refer No Result

_____ **L** Pass Refer No Result

Date

Second Screen: **R** Pass Refer No Result

_____ **L** Pass Refer No Result

4. RISK ASSESSMENT (check all that apply)

FOR LATER-ONSET CHILDHOOD HEARING LOSS:

___ Family History of Permanent Hearing Loss <18 yrs of age

___ NICU stay >5 days

___ Syndrome Associated with HL (e.g. Downs)

___ Congenital Infection (e.g. T-O-R-C-H)

___ Postnatal Infection (e.g. Meningitis)

___ Craniofacial Anomalies- _____

___ Ototoxic Medications - any amount

___ Mechanical Ventilation - any amount

___ Parent or Physician Concern

___ Head Trauma ___ Other _____

(monitoring through age 3 is recommended for most risk factors)

Nursing/screening staff will inform you of the final results of the baby's newborn hearing screen and give you a copy of these results. If your baby needs testing or follow-up for risks, you will be given an appointment and/or follow-up information. If you have any questions about testing, or need information on financial assistance, please contact Idaho's Early Hearing Program, Idaho Sound Beginnings, at (208) 334-0829.

Your baby referred on the hearing screen. Diagnostic testing needs to be completed before baby is **3 months** old. If baby is not hearing **all** the sounds necessary for speech and language development, early identification can minimize communication delays.

Your baby is at risk for later-onset childhood hearing loss. Diagnostic testing at approximately **9-12 months** of age is recommended for most risk factors. A Pediatric Audiologist can advise on the appropriate monitoring schedule for your baby.

Audiologist: _____

Phone: _____

Address: _____

(For a listing of *Pediatric* Audiologists call Idaho Sound Beginnings at: (208) 334-0829)

I have been informed of my baby's hearing screen results and of the need for diagnostic audiology (hearing) testing before the age of 3 months (if baby did not pass) to determine if a hearing loss is present. If baby passed the hearing screen, but risk factors are present (see above), hearing testing is recommended at approximately 9 months of age. (American Academy of Pediatrics (AAP) Guidelines)

I hereby give permission to the staff of the above-named hospital/screening site to release medical information necessary to complete an audiology evaluation for my child to the listed audiologist/clinic (or the audiologist of my choice) and physician. I also give permission to the hospital and audiologist/clinic, and Idaho Sound Beginnings to share the results of the hearing screening and diagnostic audiology evaluations with the above-named physician, the Idaho Infant-Toddler Program, Idaho School for the Deaf and Blind, Idaho Hands & Voices, and other states' EHDI Coordinators, as needed.

I understand that the information will only be used to ensure that appropriate and timely medical, educational, and audiologic services are made available to my child.

Hearing screening results are reported to Idaho Sound Beginnings-Idaho's Early Hearing Detection & Intervention Program and are not shared with the above listed entities or any other outside entities without parent/guardian consent.

I have had the opportunity to read this clinic's Notice of Privacy Practices. I understand that this information will not be shared with unauthorized individuals. This authorization expires 36 months from the date signed.

PARENT/GUARDIAN : _____ **DATE :** _____



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Department of Health and Welfare, Infant Toddler Program

AUDIOLOGY RESULTS FORM BIRTH TO 3 YEARS

Please enter details regarding patient's hearing status, testing and recommendations. Complete (or verify) contact and risk information on side one.

Reason for Testing:

- Hearing Screening Refer -
- Risk Indicators or Concerns -

FAX completed form to 208-332-7331 within 5 days of evaluation.

BABY'S INFORMATION:

Baby's Name: _____

Mothers Name: _____
Last First

DOB: ____/____/____ Gender: M F

Name of Birth Hospital: _____

Baby's Primary Care Provider: _____

SIDE 1 OF FORM SHOULD BE USED TO ENTER RISK FACTOR AND CONTACT INFORMATION OR ATTACH THE HOSPITAL REFERRAL FORM IF AVAILABLE.

DIAGNOSTIC TEST BATTERY:

ABR Click - Wave V threshold (dBeHL)

Air - RIGHT ____ LEFT ____

Bone - RIGHT ____ LEFT ____

Tone - (kHz) .5 1 2 4

Air - RIGHT ____

LEFT ____

OAE TEOAE or DPOAE

<u>RIGHT</u>	<u>LEFT</u>
Pass ____	Pass ____
Refer ____	Refer ____
Could Not Test ____	Could Not Test ____

ACOUSTIC IMMITTANCE

TYMPANOMETRY: Hz- _____

Type RIGHT: _____ LEFT: _____

BEHAVIORAL- threshold VRA ____ CPA ____

(kHz) - .5 1 2 4 8 - Speech

RIGHT ____ (dB HL)

LEFT ____ (dB HL)

Sound Field ____ (dB HL)

DATE OF EVALUATION: _____

- This is baby's first visit to audiologist -
- This is **Follow-up** testing after initial visit -

DIAGNOSIS: (STATUS OF HEARING AT THIS VISIT)

Hearing Loss-	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> No	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Degree of Loss-	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> Mild	<input type="checkbox"/> Mild
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Mod-Severe	<input type="checkbox"/> Mod-Severe
	<input type="checkbox"/> Severe	<input type="checkbox"/> Severe
	<input type="checkbox"/> Profound	<input type="checkbox"/> Profound

Type of Loss-	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> Conductive-fluctuating	<input type="checkbox"/> Conductive-fluctuating
	<input type="checkbox"/> Conductive-permanent	<input type="checkbox"/> Conductive-permanent
	<input type="checkbox"/> Sensorineural	<input type="checkbox"/> Sensorineural
	<input type="checkbox"/> Mixed	<input type="checkbox"/> Mixed
	<input type="checkbox"/> Central/Neural	<input type="checkbox"/> Central/Neural
	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined

FOLLOW-UP CHECKLIST:

REPORT ALL RESULTS TO IDAHO SOUND BEGINNINGS (Birth-3)

- Audiologic Re-evaluation and/or Monitoring needed
When/How often? _____
Return Appointment Pending: yes no
- Referred for Medical Follow-up/ENT Consult-Clearance
- No Follow-up is needed -*Referred to Medical Home*
- Lost to Follow-up-*Discharged after no response/no show*
- Amplification is Recommended
- Ophthalmology Exam is Recommended
- Genetic Counseling is Recommended

IF A HEARING LOSS HAS BEEN IDENTIFIED -

- Referral has also been made to Infant Toddler Program

COMMENTS/NOTES:

Mail to: Idaho Sound Beginnings-ITP
450 W. State St. FI-5 (208) 334-0829
Boise, ID 83720

Fax to: (208) 332-7331

(Audiologist Signature)
Clinic Name: _____