EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

Screening Report Form

For newborn hearing screenings performed on babies that you cannot view in the OVERS system (e.g., babies not born in your hospital/birth center, such as transferred babies or home births), please fax the following information to the EHDI Program at 971-673-0251.

All other hearing screenings should be recorded in the OVERS system, whether performed as inpatient or outpatient procedures.

Child's Name (Last, First):	**Parent/Guardian Name (Last, First):**
Date of Birth: ____/____/_____ **Birth Facility:**	**Sex:** ☐ Male ☐ Female
Medical Record Number:	**Address:** **City:** **State:** **Zip Code:**
Primary Language in the Home:	**Phone Number:** ( ) -
Primary Health Care Provider: **Facility:**	**Primary Health Care Provider Phone:** ( ) -

Please select any risk factors for hearing loss that apply to this child:

Family history of permanent hearing loss present at birth or originating in childhood
>5 day admission to NICU
In-utero infection (e.g., CMV, herpes, toxoplasmosis)
Craniofacial anomaly (e.g., ear pit/tag, cleft lip/palate, aural microtia/atresia)
Syndrome associated w/ hearing loss (e.g., CHARGE, Waardenburg, Trisomy 21, Long QT)
Other:

Date of Evaluation: ____/____/_____
Screening Facility: _____

	Left Ear		Right Ear	
OAE	Pass	Refer	Pass	Refer
AABR	CNT/ DNT*	Declined/Waived**	CNT/ DNT*	Declined/Waived**

*** Indicate reason not performed:**

No show / Cancel — **Rescheduled** (Date: _____)
Unable to contact
Moved out of state

Equipment failure — **Rescheduled** (Date: _____)

Physical Condition of Ear (Describe: _____)
Other (Describe: _____)

**** Obtain signed decline/waiver form**

06/2014