Hearing Results
Newborn Screening Program
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73117-1299
405-271-6617

Dear Clinician: *If the infant's parent/guardian did not bring a similar form that includes the infant's identifying information, use this form to report hearing screening or audiologic diagnostic results to the newborn screening program. Please return the completed form to the address above or FAX it to 405-271-4892.*

Infant's last name: **Infant's first name:** **DOB:**

Mom's last name: **Mom's first name:** **Mom's SS#:**

Address: **City:** **State:** **Zip:**

Birth Facility: **Primary Care Physician (PCP) Name :**

To the clinician evaluating hearing: *Complete Box 1 if you are screening hearing; complete Box 2 if you are providing a diagnostic audiologic assessment.*

Box 1: Hearing Screening Results

Screening Date:

Results:

Right Ear: □ Pass □ Refer **Left Ear**: □ Pass □ Refer **Screen Method**: □ ABR □ OAE □ other_____

Early Intervention: □ Referred □ Already enrolled Location: _____

Comments:

Person screening: _____ **Title:**_____ **Phone:**_____

Box 2: Diagnostic Audiologic Assessment Results

Assessment Date: **Seen previously?** □ Yes □ No **If Yes, Date:**

Results:

Right Ear: □ Normal □ Slight Loss □ Mild Loss □ Moderate Loss □ Severe Loss □ Profound Loss □ Inconclusive
□ Sensorineural □ Conductive □ Mixed □ ANSD □ Undetermined

Left Ear: □ Normal □ Slight Loss □ Mild Loss □ Moderate Loss □ Severe Loss □ Profound Loss □ Inconclusive
□ Sensorineural □ Conductive □ Mixed □ ANSD □ Undetermined

Assessments used: (Check all that apply) □ ABR □ Bone ABR □ ASSR □ TEOAE □ DPOAE □ BOA □ VRA
□ Pure Tone □ Tympanometry □ other_____

Early Intervention: □ Referred □ Already enrolled Location: _____

Amplification: Date _____ Type: □ Hearing Aid □ Cochlear Implant □ other_____

Referrals/Resources: □ PCP □ ENT □ Genetics □ Ophthalmology □ other_____

Risk Factors/Family History:_____

Recommendations/Comments:

Audiologist: _____ **Phone** _____