

## Physician Form to Fax Results of Outpatient Hearing Screen or Diagnostic Audiological Evaluation to State Newborn Hearing Screening Program

Date:		
Dr:	Practice:	;
Phone:	Fax:	
<b>RE:</b> The following child in your ca	are <i>DID NOT PASS</i> (	OR <i>DID NOT RECEIVE</i> the Newborn Hearing Scree
Child:		DOB:
Parent:		Hospital:
		nt hospital hearing screen (if available), or to a local ation. Please complete the appropriate section(s) below
Outpatient Hearing Screen:  Outpatient Hearing Screen Scheduled Date: Location: Phone:	as follows:	☐ Outpatient Hearing Screen Completed as follows  Date: Location:  Phone:  Results: Right Ear: ☐ Pass ☐ Refer  Left Ear: ☐ Pass ☐ Refer
Diagnostic Hearing Evaluation:  ☐ Diagnostic Hearing Evaluation Schedu Date: Location: Phone:	aled as follows:	Lett Lat1 assRefer
Diagnostic Hearing Evaluation C	Completed on:	at:
Results of Diagnostic Hearing Ex Diagnostic ABR: Right ear threshold: dBnHL Left ear threshold: dBnHL	valuation (Complete A 500 1000	All that Apply OR Fax Copy of Audiological Report).  2000 4000 Hz
Degree of hearing loss:  Normal Mild (16- 35 dbHL) Moderate (36-50 dbHL) Moderate/Severe (51-70 dbHL) Severe (71-90 dbHL) Profound (91 or greater dbHL) Comments:	Hearing Loss:  Unilateral Bilateral	Type of Hearing Loss:  Conductive/Fluctuating conductive Sensorineural Mixed Auditory Neuropathy/Dyssynchrony

Please Complete Within 48 hours of Receipt & Fax Back to Newborn Hearing Screening

Program at 505-476-8817. If you have questions or need additional information, call

1-877-890-4692.

