

Ohio Department of Health – Infant Hearing Program Universal Newborn Hearing Screening Report

Hospital Name
Infant's Medical Record Number

Addressograph or label (optional) – all copies

Birth See instructions on back

<input type="checkbox"/> Single <input type="checkbox"/> Multiple: Code #: _____ Order delivered: _____				Infant's birthdate (mm/dd/yyyy)	
Infant's name <i>last</i> <i>first</i> <i>middle initial</i> <i>suffix</i>					
Mother's name <i>last</i> <i>first</i> <i>middle initial</i> <i>maiden</i>					
Mother's address – Number and street				Apartment	County of residence
City		State	Zip		Country, if not US
Phone number <input type="checkbox"/> Cell phone			Alternate phone number		<input type="checkbox"/> No phone

Discharge Caregiver, if Mother, check Not Applicable. If NOT, add code # and complete below

<input type="checkbox"/> Not applicable <input type="checkbox"/> Code #: _____	
Name	Relationship
Address	Phone number

Primary Care Provider Physician/Nurse Practitioner who will care for infant after hospital discharge

Provider name <i>last</i> <i>first</i> <i>middle initial/suffix</i>		Title	
Practice name			Office phone number
Practice address		City	State
		Zip	

Hearing Screening Fill out section completely

Hearing Screening Completed?		If not, why?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Objected	<input type="checkbox"/> Transferred	<input type="checkbox"/> Deceased Date: _____	<input type="checkbox"/> Equipment malfunction
		<input type="checkbox"/> Early discharge	<input type="checkbox"/> Missed	<input type="checkbox"/> Physical anomaly	

First screening results Second screening results

First screening results			Second screening results		
Screener name			Screener name		
Date (mm/dd/yyyy)			Date (mm/dd/yyyy)		
Method <input type="checkbox"/> ABR <input type="checkbox"/> DPOAE <input type="checkbox"/> TEOAE			Method <input type="checkbox"/> ABR <input type="checkbox"/> DPOAE <input type="checkbox"/> TEOAE		
Right Ear		Left Ear	Right Ear		Left Ear
<input type="checkbox"/> Pass <input type="checkbox"/> Non-pass		<input type="checkbox"/> Pass <input type="checkbox"/> Non-pass	<input type="checkbox"/> Pass <input type="checkbox"/> Non-pass		<input type="checkbox"/> Pass <input type="checkbox"/> Non-pass

Risk Factors Check all that apply

<input type="checkbox"/> Unknown	<input type="checkbox"/> Family history of childhood hearing loss	<input type="checkbox"/> Ototoxic medications
<input type="checkbox"/> None	<input type="checkbox"/> Craniofacial anomalies	<input type="checkbox"/> Head trauma
<input type="checkbox"/> Illness of 5 days or greater in NICU	<input type="checkbox"/> In utero infections (TORCHS)	<input type="checkbox"/> Caregiver concern
<input type="checkbox"/> Syndromes associated with hearing loss	<input type="checkbox"/> Culture positive postnatal infections	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Physical findings associated with hearing loss	<input type="checkbox"/> Neurodegenerative disorders	

Transfer Information Indicate location and date transferred Not applicable

<input type="checkbox"/> To:		State (if not Ohio):
<input type="checkbox"/> From:		State (if not Ohio):

Mail to Ohio Department of Health, Infant Hearing Program, 246 North High Street, 5th Floor, Columbus, OH 43215 within 10 days of screening.
For assistance, contact the Infant Hearing Program by telephone at 614-644-8389.

Universal Newborn Hearing Screening Report

Section 3701.505 of the Ohio Revised Code states that infants born in hospitals or freestanding birthing centers will receive hearing screenings prior to discharge. Under Ohio law, hospitals must notify the Ohio Department of Health of newborns' or infants' hearing screening results within **10 days** from when hearing screenings were conducted in accordance with rule 3701-40-02 of the Administrative Code.

I. Hospital Information

1. **Hospital Name**— Enter official hospital name, not abbreviated name or initials.
2. **Infant's Medical Record Number**— Obtain this number from the chart.
3. **Addressograph or Label Space** (optional)—Information needs to go on all four copies.

II. Patient Demographics and Primary Care Provider

1. **Birth**— Check single or enter correct code for multiple:
2 (twin)
3 (triplet) etc.

If multiple, indicate order delivered:
1st, 2nd, 3rd, 4th, etc.

2. **Infant Birth Date**— Two-digit month, two-digit date, four-digit year: MM/DD/YYYY.

3. **Infant's Legal Name as Indicated on the Birth Certificate**—First and last names are **required**; enter middle initial and suffix if known/applicable.

4. **Mother's Name**— First and last names are **required**; maiden name if applicable.

5. **Mother's Address**— Mailing address is **required**: number and street name; apartment number; county; city, town or location; state (use two- letter abbreviation); zip code; and country (if not in U.S.).

6. **Telephone**— 10 digit number, including area code for primary and alternate phones where someone can contact the mother. Check the 'No phone' box if there is **no telephone**.

7. **Discharge Caregiver if NOT Mother**— If the baby is going home with the mother, check the '**Not Applicable**' box. If someone else will be the caregiver, list the correct code number:

- 1 (legal guardian)
- 2 (adoption agency)
- 3 (other: state relationship)

List the discharge caregiver's name, address and contact phone number.

Mail the green copy to:

Infant Hearing Program
Ohio Department of Health
246 North High Street, 5th Floor
Columbus, OH 43215

8. **Infant's Primary Care Provider** (Physician/Nurse Practitioner) — First name, Last name and Title (MD, DO, CNP) are **required**. Suffix, if applicable: Jr., Sr., I, II, III, etc.

Practice Name— Name of primary care provider's practice and phone number, if known.

Practice Address— Required for all primary care providers.

III. Hearing Screening

1. **Hearing Screening Completed?**— Check Yes or No. If screening was **NOT** completed, reason is **required**. Check one of the boxes: objected, transferred, deceased, etc.

2. **First Hearing Screening Results**— (all fields **required** if answered Yes above).

Date— Date screening conducted in MM/DD/YYYY format.

Screener Name — First and last names are required.

Method— Check method: ABR, TEOAE or DPOAE.

Right Ear— Check either Pass or Non-pass.

Left Ear— Check either Pass or Non-pass.

3. **Second Hearing Screening Results** — **Required** if Non-pass selected in First Screening for either ear. Check Pass or Non-pass for both ears rescreened. Both ears are **required** to be rescreened, even if only one ear referred.

IV. Risk Factors

Please see Joint Committee on Infant Hearing 2007 Position Statement for more details on risk factors.

<http://pediatrics.aappublications.org/content/120/4/898.full.html>

Check all risk factors that apply.

If no information is known regarding risk factors, check '**Unknown**'.

If the infant has risk factors other than those listed on this form, check '**Other**'. Other may include ECMO, assisted ventilation, loop diuretics, or hyper bilirubinemia requiring exchange transfusion. Please indicate.

V. Transfer Information

Not Applicable if the infant was not transferred.

If infant was transferred complete the following:

To— List facility infant transferred to.

From— List facility infant transferred from.

Date— Date infant transferred.

State— If not Ohio.

