Ohio Department of Health • Infant Hearing Program

UNHS Follow-up Hearing Evaluation

Patient Information

Infant's name/Also known as	Sex ☐ Male ☐ Female	Date of birth / /
Parent/guardian's name	Parent/guardian's phone ( )	Alternate phone ( )
Parent/guardian's address— Number and street/Apt. #		
City / State / ZIP	County of residence	
Primary/referring physician's name		Physician's phone ( )

Reason for referral

☐ UNHS refer ☐ Parent concern ☐ Other _____ ☐ MD referral _____

Hospital Screening

Hospital of birth

Screening type ☐ OAE ☐ ABR **Right ear results** ☐ Pass ☐ Refer **Left ear results** ☐ Pass ☐ Refer

Hearing Evaluation

Date of evaluation / /	Performed by (audiologist's name)
Audiologist's phone ( )	Audiologist's practice/Facility name

Screening

Screening results			Tympanometry			
	☐ OAE	☐ ABR		☐ 226 Hz	☐ 1000 Hz	
Right ear	☐ Pass	☐ Refer	Right ear	☐ Normal	☐ Abnormal	☐ Not tested
Left ear	☐ Pass	☐ Refer	Left ear	☐ Normal	☐ Abnormal	☐ Not tested

Diagnostic Evaluation Check all that apply

☐ Click ABR ☐ Bone conduction ABR ☐ DPOAE ☐ Acoustic reflexes ☐ VRA
☐ Toneburst ABR ☐ TEOAE ☐ ASSR ☐ Play/Behavioral ☐ BOA

Hearing Disposition Select type and degree

Degree of hearing loss

R	L	
☐	☐	Hearing within normal limits
☐	☐	Mild
☐	☐	Mild—Moderate
☐	☐	Moderate
☐	☐	Mod—Severe
☐	☐	Severe—Profound
☐	☐	Undetermined

Type of hearing loss

R	L	
☐	☐	NA/No hearing loss
☐	☐	Sensorineural hearing loss
☐	☐	Mixed hearing loss
☐	☐	Permanent conductive HL
☐	☐	Fluctuating conductive HL
☐	☐	Auditory neuropathy
☐	☐	Undetermined

Confirmed Hearing Loss ☐ **YES Right** ☐ **YES Left**

Date confirmed

Unable to Complete Testing ☐ **Right** ☐ **Left**

Reason

F/U date

Recommendations/Referrals

☐ **No referral—Normal hearing**

☐ Repeat hearing testing _____
☐ Primary care provider (PCP) _____
☐ Medical specialist (ENT/OTO) _____
☐ Regional Infant Hearing Program RIHP _____
☐ Early Intervention Program _____
☐ Audiologic monitoring (Risk factors listed on back of page)
☐ Speech/Language services _____
☐ Amplification _____
☐ Genetic referral _____
☐ Other _____

Results are to be FAXED to: **Infant Hearing Program, Ohio Department of Health at 614-728-9163**
or mailed to: **Ohio Department of Health, Infant Hearing Program, 246 North High Street, 5th floor, Columbus, OH 43215**
For assistance, contact the Infant Hearing Program by telephone at 614-644-8389 or at http://www.odh.ohio.gov

Follow-up Hearing Evaluations

Ohio Administrative Code (OAC) Chapter 3701-40-02 requires Audiologists/Providers of Follow-Up to:

a) Provide newborns that do not pass UNHS (hospital hearing screening) a full hearing evaluation consistent with *JCIH 2007 Recommendations.

b) Report hearing evaluation Results to ODH on the UNHS Follow-Up Evaluation Reporting Form (HEA 8017) and to the infant's PCP certified nurse-midwife or certified nurse practitioner.

For information about audiological assessment for newborns and infants, see American Speech Language Hearing Association reference guidelines, Audiological Assessment of Children Birth to Five Years of Age, 2004 at: http://www.asha.org/docs/pdf/GL2004-00002.pdf

JCIH 2007 Evaluation Highlights

Audiological testing must include an ABR if (a) the hospital screening included an ABR or (b) testing is conducted more than one month following the infant's discharge from the birthing facility. Audiological testing should (c) assess both ears even if only one ear did not pass the screening and (d) include test procedures to assess the integrity of the auditory system, estimate hearing sensitivity, and determine the type of hearing loss.

*See "Pediatrics", Vol. 120, # 4, Oct, 2007, pp 898 to 921 or http://www.jcih.org/posstatements.htm for complete article.

Risk Indicators associated with Permanent Congenital, Delayed-Onset, or Progressive Loss

☐ 1) Caregiver concern regarding hearing, speech, language, or developmental delay.

☐ 2) Family history of permanent childhood hearing loss.

☐ 3) Neonatal intensive care of more than 5 days, ECMO, assisted ventilation, ototoxic medications, loop diuretics and hyperbilirubinemia that requires exchange transfusion.

☐ 4) In utero infections, such as CMV, herpes, rubella, syphilis, and toxoplasmosis.

☐ 5) Craniofacial anomalies, including those of the pinna, ear canal, ear tags, ear pits, temporal bone.

☐ 6) Physical findings associated with a sensorineural or permanent conductive hearing loss syndrome.

☐ 7) Syndromes associated with hearing loss or progressive or late-onset hearing loss including neuro-fibromatosis, osteopetrosis, Usher; Waardenburg, Alport, Pendred, Jervell, Lange-Nielson.

☐ 8) Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome.

☐ 9) Culture-positive postnatal infections including herpes, varicella, and meningitis.

☐ 10) Head trauma, especially basal skull/temporal bone fracture that requires hospitalization.

☐ 11) Chemotherapy.

Instructions for completion of the HEA 8017 form

Patient Information section

- Complete the Infant legal name, DOB, parent/guardian name, PCP name and contact information, including primary and alternate phone numbers for parent, as well as PCP.
- Indicate the reason for the referral.

Hospital screening information section

- Complete the birth hospital name and hearing screening information (type of screening and results) if known.

Hearing Evaluation Section

- Complete the date of evaluation/appointment, audiologists name, phone information and name of facility.

Screening Section

- Complete this section if a screening is performed as part of outpatient testing for EACH EAR.
- Complete Tympanometry section for EACH EAR.

Diagnostic Section

- Mark ALL tests performed as part of the evaluation.

Hearing Disposition Section

- Mark or check the Degree and Type for EACH EAR.
- If a Hearing Loss is identified indicate this in the Confirmed Hearing Box.
- Indicate if testing was not completed and the date of the FU testing.

Recommendations/Referrals

- If hearing is normal mark this box.
- After form is complete fax or mail to ODH Infant Hearing Program.
- If there is recommendation or other referrals, please mark the appropriate box.