Early Hearing Detection & Intervention

EHDI Arkansas

Infant Hearing Initial Screening

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Child Last Name: | Date of Birth: - - 202

Child First Name: | Child Medical Record #

Sex: M ☐ F ☐ | Gestational Age: | Birth Weight: | Plurality: 1) Single 2) Twins 3) Triplets 4) Quadruplets 5) Quintuplets 6) Sextuplets 7) Septuplets 8) Octuplets 9) Unknown

Birth Hospital: | Birth Facility #: - H

Transferred to:

PCP Group: | Home Birth: ☐

Contact Information: *Please identify contact as* Mother ☐ Agency ☐ Guardian ☐ Adoption Pending ☐

Last Name: | Mo. Medical Record #:

First Name: | If guardian, relationship to child:

Contact's Primary Language: English ☐ Spanish ☐ Other ☐ | Biological Parent: Yes ☐ No ☐ Not Applicable ☐

Address Line 1: | Primary Phone Number:

Address Line 2: | - -

City: | Alternate Phone Number:

State: | Zip Code: | - -

Second Contact | Relationship to Child:

Last Name: | Primary Phone: - -

First Name: | Alternate Phone: - -

Screening Information

Screening Facility Name (if different from Birth Facility): | **Screening Date:** - - 202

Screening Facility #: -

Tester First Initial: | Tester Last Name: | Tester Title:

Basic Insurance Type: Public ☐ Private ☐ Self Pay ☐

Has this baby been discharged once since birth? Yes ☐ No ☐

Risk Factors: Immediate Neonatal Period

- ☐ Family history of permanent childhood hearing loss
- ☐ NICU Admission of more than 5 days
- ☐ ECMO
- ☐ Assisted ventilation
- ☐ Ototoxic medications
- ☐ Loop diuretics
- ☐ Hyperbilirubinemia requiring exchange transfusion
- ☐ Suspected in-utero infections (e.g. CMV, herpes, rubella, syphilis, toxoplasmosis)
- ☐ Craniofacial anomalies including involvement of the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies

Risk Factors: After Immediate Neonatal Period

- ☐ Caregiver concerns about hearing, speech, language, or developmental delay
- ☐ Physical finding associated with a syndrome involving hearing loss (e.g. white forelock)
- ☐ Neurodegenerative disorder
- ☐ Post-natal infections (e.g. herpes, varicella, meningitis)
- ☐ Head trauma
- ☐ Diagnosed Cytomegalovirus (CMV)
- ☐ Chemotherapy

Screening Method and Test Results

Method of Screening: OAE ☐ AABR ☐

Left Ear: Pass ☐ Fail ☐ DNT ☐ Reason ( )

Right Ear: Pass ☐ Fail ☐ DNT ☐ Reason ( )

Please indicate reason for DNT(Did Not Test): Equipment Down(1) Discharge before Test(2) Emergency Transfer(3) Infant Expired(4) Parental Refusal(5) Atresia(6) Non-Hospital Birth(7) Previously Passed(8)

Infant Hearing Appointment Scheduling (*As indicated, please make appointment for either a Rescreen or Diagnostic Test Battery*) Comfort Care Discharge ☐

Post-discharge Initial Screen ☐ **Rescreen** ☐ **Diagnostic Test Battery** ☐

Hospital or Clinic Name (if different from Birth Facility):

Appointment Date: - - 202

Appointment Time: : AM ☐ PM ☐

PCP Group Referral sent to: