Reset Form

Print Form

Audiology Report for the Newborn Screening Program

FAX completed report to 651-215-6285

*** Please be sure to send a copy of any results to the child's primary care provider.**

Child: Last: First: Sex: M ☐ F ☐ DOB:

Address: City: ZIP:

Child's Health Insurance: ☐ Private ☐ MN Public ☐ Self Pay ☐ Other ☐ Unknown

Parent/Guardian Name: Last: First: Relationship:

Phone: Alt. Phone: **Language Used in Home:**

Audiologist: Clinic:

Primary Care Provider: Clinic:

Complete the section(s) appropriate for your evaluation . Do NOT delay complete diagnosis solely due to middle ear dysfunction!

APPOINTMENT CHANGE: Date: New Appt. Date:

☐ Family cancelled ☐ Family did not show Reason No Appt. Made:

SCREENING RESULTS: Date: **Important: Screen both ears**

Right Ear: ☐ Pass ☐ Refer **Left Ear:** ☐ Pass ☐ Refer **Tech:** ☐ OAE ☐ AABR /or Click ABR

Diagnostic Appt Made: Date: Facility:

DIAGNOSTIC HEARING RESULTS: **Date of Evaluation:**

Degree of Hearing Loss

RIGHT EAR	LEFT EAR
☐ **Normal**	☐ **Normal**
☐ Slight	☐ Slight
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Moderately Severe	☐ Moderately Severe
☐ Severe	☐ Severe
☐ Profound	☐ Profound

Type of Hearing Loss

Right Ear:

☐ Sensory(Cochlear) ☐ Neural(AN) ☐ Cond

Left Ear:

☐ Sensory(Cochlear) ☐ Neural(AN) ☐ Cond

*** If this is a Confirmed Hearing Loss, please fax dictation/appt. summary along with this form***

Any Additional Comments:

Newborn Screening Program
P.O. Box 64899, St. Paul, MN 55164-0899
FAX: (651) 215-6285; Phone: (651) 201-5466 or 800-664-7772,
www.health.state.mn.us/newbornscreening