



# IDAHO SOUND BEGINNINGS (ISB)

Early Hearing Detection and Intervention  
Department of Health and Welfare, Infant Toddler Program

**FAX TO (208) 332-7331**

Within 5 days

Newborn  
Hearing  
Screening  
Referral Form

Complete Form for All: Refers  Risks  Transfers\*  Missed  or Incomplete

Birth Hospital: \_\_\_\_\_

(\*Transfers only) Receiving Hospital: \_\_\_\_\_ [Please Press Firmly]

Within **5 days** of screening or discharge— Distribute copies to: Audiologist - **White** ISB - **Gold** Hospital - **Pink** Parent - **Green** Physician - **Yellow**

Send to: Idaho Sound Beginnings-EHDI, PO Box 83720, Boise, ID 83720-9815 or Fax: (208) 332-7331

## 1. BABY'S INFORMATION:

Baby's Med Record #: \_\_\_\_\_

Baby's Name: \_\_\_\_\_  
Last First

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Nursery:  Well Baby  NICU/Special Care

Baby's Primary Physician/Clinic: \_\_\_\_\_

Mother's name: \_\_\_\_\_

## 2. CONTACT INFORMATION:

Parent/Guardian: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Text? \_\_\_\_\_

Alternate Phone/Contact: \_\_\_\_\_

Email/other contact: \_\_\_\_\_

## 3. HEARING SCREEN RESULTS:

First Screen: R  Pass  Refer  No Result

\_\_\_\_\_ L  Pass  Refer  No Result

Date

Second Screen: R  Pass  Refer  No Result

\_\_\_\_\_ L  Pass  Refer  No Result

## 4. RISK ASSESSMENT (check all that apply)

### FOR LATER-ONSET CHILDHOOD HEARING LOSS:

\_\_\_\_ Family History of Permanent Hearing Loss <18 yrs of age

\_\_\_\_ NICU stay >5 days

\_\_\_\_ Syndrome Associated with HL (e.g. Downs)

\_\_\_\_ Congenital Infection (e.g. T-O-R-C-H)

\_\_\_\_ Postnatal Infection (e.g. Meningitis)

\_\_\_\_ Craniofacial Anomalies- \_\_\_\_\_

\_\_\_\_ Ototoxic Medications - any amount

\_\_\_\_ Mechanical Ventilation - any amount

\_\_\_\_ Parent or Physician Concern

\_\_\_\_ Head Trauma \_\_\_\_\_ Other \_\_\_\_\_

(monitoring through age 3 is recommended for most risk factors)

Nursing/screening staff will inform you of the final results of the baby's hearing screen and give you a copy of these results. If your baby **needs testing** or follow-up for risks, you will be given an appointment and/or follow-up information. If you have questions please contact **Idaho's Early Hearing Program, Idaho Sound Beginnings, at (208) 334-0829. Financial Assistance for diagnostic testing may be available.**

Your baby **did not pass** the hearing screen. Hearing testing should be completed before baby is **3 months** old. If baby is not hearing **all** the sounds necessary for speech and language development early identification can minimize any communication delays.

Your baby is **at risk for later-onset childhood hearing loss**. Hearing testing at approximately **9 months** of age is recommended for most risk factors. A Pediatric Audiologist can advise on the appropriate monitoring schedule for your baby.

Audiologist: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Appt. date/time: \_\_\_\_\_

I have been informed of my baby's hearing screen results and of the need for diagnostic audiology (hearing) testing before the age of 3 months (if baby did not pass) to determine if a hearing loss is present. If baby passed the hearing screen, but risk factors are present (see above), hearing testing is recommended at approximately 9 months of age. (American Academy of Pediatrics (AAP) Guidelines)

I hereby give permission to the staff of the above-named hospital/screening site to release medical information necessary to complete an audiology evaluation for my child to the listed audiologist/clinic (or the audiologist of my choice) and physician. I also give permission to the hospital and audiologist/clinic, and Idaho Sound Beginnings to share the results of the hearing screening and diagnostic audiology evaluations with the above-named physician, the Idaho Infant-Toddler Program, Idaho School for the Deaf and Blind, and Idaho Hands & Voices. I understand that the information will only be used to ensure that appropriate and timely medical, educational, and audiologic services are made available to my child.

Hearing screening results are reported to Idaho Sound Beginnings -Idaho's Early Hearing Detection & Intervention Program and are not shared with the above listed entities or any other outside entities without parent/guardian consent.

I have had the opportunity to read this clinic's Notice of Privacy Practices. I understand that this information will not be shared with unauthorized individuals. This authorization expires 36 months from the date signed.

**PARENT/GUARDIAN :** \_\_\_\_\_

**DATE :** \_\_\_\_\_



# IDAHO SOUND BEGINNINGS

Early Hearing Detection and Intervention (EHDI)  
Department of Health and Welfare, Infant Toddler Program

**AUDIOLOGY RESULTS**  
**BIRTH TO 3 YEARS**

Please enter details regarding patient's hearing status, testing and recommendations. Complete (or verify) contact and risk information on side one.

**FAX to 208-332-7331 within 5 days of evaluation.**

### Reason for Testing:

- Hearing Screening Refer -
- Risk Indicators or Concerns -

### BABY'S INFORMATION:

Baby's Name: \_\_\_\_\_

Mothers Name: \_\_\_\_\_  
Last First

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Name of Birth Hospital: \_\_\_\_\_

Baby's Primary Care Provider: \_\_\_\_\_

**SIDE 1 OF FORM SHOULD BE USED TO ENTER RISK FACTOR AND CONTACT INFORMATION OR ATTACH THE HOSPITAL REFERRAL FORM IF AVAILABLE.**

### DIAGNOSTIC TEST BATTERY:

**ABR** Click - Wave V threshold (dBeHL)

Air - RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

Bone - RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

Tone - (kHz) .5 1 2 4

Air - RIGHT \_\_\_\_\_

LEFT \_\_\_\_\_

**OAE**  TEOAE or  DPOAE

RIGHT LEFT

Pass \_\_\_\_\_ Pass \_\_\_\_\_

Refer \_\_\_\_\_ Refer \_\_\_\_\_

Could Not Test \_\_\_\_\_ Could Not Test \_\_\_\_\_

**ACOUSTIC IMMITTANCE**

TYMPANOMETRY: Hz- \_\_\_\_\_

Type RIGHT: \_\_\_\_\_ LEFT: \_\_\_\_\_

**BEHAVIORAL- threshold** VRA \_\_\_\_\_ CPA \_\_\_\_\_

(kHz) - .5 1 2 4 8 - **Speech**

RIGHT \_\_\_\_\_ (dB HL)

LEFT \_\_\_\_\_ (dB HL)

Sound Field \_\_\_\_\_ (dB HL)

### DATE OF EVALUATION: \_\_\_\_\_

- This is baby's first visit to audiologist -
- This is **Follow-up** testing after initial visit -

### DIAGNOSIS: (STATUS OF HEARING AT THIS VISIT)

<b>Hearing Loss-</b>	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> No	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

<b>Degree of Loss-</b>	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> Mild	<input type="checkbox"/> Mild
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Mod-Severe	<input type="checkbox"/> Mod-Severe
	<input type="checkbox"/> Severe	<input type="checkbox"/> Severe
	<input type="checkbox"/> Profound	<input type="checkbox"/> Profound

<b>Type of Loss-</b>	RIGHT EAR	LEFT EAR
	<input type="checkbox"/> Conductive-fluctuating	<input type="checkbox"/> Conductive-fluctuating
	<input type="checkbox"/> Conductive-permanent	<input type="checkbox"/> Conductive-permanent
	<input type="checkbox"/> Sensorineural	<input type="checkbox"/> Sensorineural
	<input type="checkbox"/> Mixed	<input type="checkbox"/> Mixed
	<input type="checkbox"/> Central/Neural	<input type="checkbox"/> Central/Neural
	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined

### FOLLOW-UP CHECKLIST:

- RESULTS SENT TO IDAHO SOUND BEGINNINGS (ALL 0-3 yrs.)**
- No Follow-up is needed -*Referred to Medical Home*
- Lost to Follow-up-*Discharged after no response/no show*
- Audiologic Re-evaluation and/or Monitoring needed  
When/How often? \_\_\_\_\_
- Return Appointment Pending:**  yes  no
- Referred for Medical Follow-up/ENT Consult-Clearance
- Amplification is Recommended
- Ophthalmology Exam is Recommended
- Genetic Counseling is Recommended

### **IF A HEARING LOSS HAS BEEN IDENTIFIED -**

- Referral has also been made to Infant Toddler Program

### COMMENTS/NOTES:

\_\_\_\_\_  
(Audiologist Signature)

Clinic Name: \_\_\_\_\_

**Mail to:** Idaho Sound Beginnings-ITP  
450 W. State St. FI-5 (208) 334-0829  
Boise, ID 83720

**Fax to:** (208) 332-7331 208-332-733