



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

Early
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, 450 W State St 5th Fl Boise, ID 83702 or Fax: (208) 332-7331

1. BABY'S INFORMATION:

Baby Vital Record #: _____

Baby's Name: _____
Last First

DOB: ____/____/____ Gender: M F

Nursery: Well Baby ____ Number of days in NICU/PICU

Baby's Primary Physician/Clinic: _____

Mother's name: _____

2. CONTACT INFORMATION:

Parent/Guardian: _____
Last First

Address: _____

City: _____ State: _____ Zip: _____

Main Phone: _____ Text? Yes / No

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)

If you have any questions about testing, or need information on financial assistance, please contact Idaho's Early Hearing Program, Idaho Sound Beginnings, at (208) 334-0829.

Your baby **REFERRED** on the hearing screen. Diagnostic testing needs to 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 communication delays.

Your baby is **AT RISK for later-onset childhood hearing loss**. Diagnostic testing at approximately **9 -12 months** of age is recommended for most risk factors. A Pediatric Audiologist can advise on the appropriate monitoring schedule for your baby.

Your Follow-Up Appointment:

Clinic: _____

Phone: _____

Appt Date: _____ Time: _____

(For a listing of Pediatric Audiologists visit www.EHDI-PALS.org)

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, diagnostic audiology evaluations, and early intervention choices (if any) with the above-named physician, the Idaho Infant-Toddler Program, Idaho School for the Deaf and Blind, Idaho Hands & Voices, and other states' EHDI Coordinators, if needed. 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 FORM
BIRTH TO 3 YEARS

FAX completed form to 208-332-7331
within 5 days of every evaluation.

Reason for Testing:
Hearing Screening Refer -
Risk Indicators or Concerns -

BABY'S INFORMATION:

Baby's Name: _____
Mothers Name: _____
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**
Present ____ Present ____
Abnormal ____ Abnormal ____
Absent ____ Absent ____
ACOUSTIC IMMITTANCE
TYMPANOMETRY: Hz- _____
Result 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)

Hearing Loss- RIGHT EAR LEFT EAR
 No No
 Yes Yes

Degree of Loss- RIGHT EAR LEFT EAR
 Mild Mild
 Moderate Moderate
 Mod-Severe Mod-Severe
 Severe Severe
 Profound Profound

Type of Loss- RIGHT EAR LEFT EAR
 Conductive-fluctuating Conductive-fluctuating
 Conductive-permanent Conductive-permanent
 Sensorineural Sensorineural
 Mixed Mixed
 Central/Neural Central/Neural
 Undetermined Undetermined

FOLLOW-UP CHECKLIST:

REPORT ALL RESULTS TO IDAHO SOUND BEGINNINGS (Birth-3)
 NO SHOW or NO RESPONSE
 Audiologic Re-evaluation and/or Monitoring needed
When/How often? _____
Return Appointment Pending: yes no
 No Follow-up is needed -*Referred to Medical Home*
The Following Recommendations / Referrals Were Made:
 Referred for Medical Follow-up/ENT Consult -Clearance
 Amplification to be Fit on _____
 Ophthalmology Exam is Recommended
 Genetic Counseling is Recommended
IF A HEARING LOSS HAS BEEN IDENTIFIED
 Referral made to Infant Toddler Program
 IESDB (brochure given)
 Idaho Hands and Voices (brochure given)
 Other EI Services _____

COMMENTS/NOTES:

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

Fax to: (208) 332-7331

(Audiologist Signature) _____

Clinic Name: _____