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's Med 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? _____

Alternate Phone/Contact: _____

Email/other contact: _____

3. HEARING SCREEN RESULTS:

First Screen:	**R**	☐ Pass	☐ **Refer**	☐ No Result
_____ Date	**L**	☐ Pass	☐ **Refer**	☐ No Result
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 :** _____

7/15

IDAHO SOUND BEGINNINGS

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

AUDIOLOGY RESULTS FORM
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 completed form 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)

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

Fax to: (208) 332-7331

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)

☐ Audiologic Re-evaluation and/or Monitoring needed
When/How often? _____
Return Appointment Pending: ☐ yes ☐ no
☐ Referred for Medical Follow-up/ENT Consult-Clearance
☐ No Follow-up is needed -*Referred to Medical Home*
☐ Lost to Follow-up–*Discharged after no response/no show*

☐ 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: _____