

## **Idaho Sound Beginnings**

### Guideline for Primary Care Physicians

#### Newborn Hearing Screening - Interpreting Results

##### 1. When there is a **NORMAL SCREEN**

Sensitivity is at or near 100 percent normal.

Does not exclude acquired hearing loss from causes such as jaundice, meningitis, serous otitis, family history of childhood hearing loss, cytomegalovirus (CMV) infection, or other high risk factors.

##### 2. When there is a **MISSED SCREEN**

There is a 3/1000 (0.3%) risk of undetected bilateral hearing loss.

The hospital determines who is responsible for recall and screening. Written notice is sent to primary care physician if does not return.

##### 3. When there is an **ABNORMAL INITIAL SCREEN** (1<sup>st</sup> stage)

The risk of hearing loss increases to 3/100 (3%) or greater.

Results are shared with family before discharge and they are asked to return in 1-2 weeks for an outpatient re-screen. Re-screening is easier to perform in first 1-2 months of life.

##### 4. When there is an **ABNORMAL RE-SCREEN** (2<sup>nd</sup> stage)

The risk of hearing loss increases to 3/10 (30%) or greater

Diagnostic Audiological Assessment is required to determine hearing status (including type and degree of loss, if any). Otoacoustic Emissions (OAE's) alone are not diagnostic test results. Diagnostic Testing should include Auditory Brainstem Response (ABR) Diagnostic Audiological Assessment should occur in 1-3 months. Hospital to notify primary care physician of need for diagnostic evaluation.

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#### 6. When the child is confirmed to be **DEAF OR HARD OF HEARING**

Unilateral (20%)

Bilateral (80%)

Only 10-20% of children will be profoundly hearing impaired

Early and consistent intervention, including hearing aids, is the key to achieving normal language development. Aids can be fit as soon as the hearing loss is identified, even infants can benefit from hearing aids.

#### 7. Primary care physician support is necessary

Encourage timely follow up with audiology and other consultants.

Evaluations may be required for speech, language, communications, cognition, motor skills, cognitive skills etc.

Otolaryngology or otology evaluation and genetic evaluations may be necessary to determine etiology.

Monitor continuous use of amplification device.

## REFERENCES

Yoshinaga-Itano, C.; Sedey, A.; Coulter, D.; Mehl, A (1998). The Language of Early and Later Identified Children with Hearing Loss. *Pediatrics*. 102(5).

National Center for Hearing Assessment and Management. Utah State University  
<http://www.infanthearing.org>