

Please **complete ALL** items and send to: DHS/EHDI: Fax **(971) 673-0251**.

Obtain (*) items at time of referral

*Referral Received: (Date) _____ (From) _____
(If referral is received from third party, begin log entry's on back side)

*Child's Last Name		*First Name	
*Date of Birth		*Gender	Male Female
*Healthcare Provider (Name or Clinic)		Child or Unique ID (as used in your clinic):	
Address Type (Check)	<input type="checkbox"/> Home <input type="checkbox"/> Mailing	*Address	
	*City	*State	*Zip
Phone Type (Check)	<input type="checkbox"/> Home <input type="checkbox"/> Work	* Phone Number	() -
Primary Language		Written Language:	
*Mother's Last Name		Mother's First Name	
*Child's Birth Hospital		Screened at birth?	Yes No Unknown

Audiologist's Name: _____ **Clinic Name :** _____
Date of Evaluation: _____ **Clinic Phone # :** _____
Evaluation: **Completed Not Completed**

Disposition: **Further evaluation needed Rescheduled (Date _____)**
 Lost / no contact Return following Medical Eval.
 Monitoring (next visit scheduled _____)
 No further contact needed Other _____

Known RiskFactor(s) (codes on back) _____
Discussed early intervention with family: Yes No EHDI refer to EI? Yes No
Was the EHDI Resource Guide provided to the family? Yes No
Genetics: Did you discuss the availability of genetic counseling? Yes No

	<u>LEFT</u>			<u>RIGHT</u>			
I. Tympanometry:	Normal	Abnormal	CNT/ DNT	Normal	Abnormal	CNT/DNT	
II. OAE or AABR (circle)	PASS	NO PASS	CNT/ DNT	PASS	NO PASS	CNT/ DNT	
III Thresholds (check method) ABR ASSR or Soundfield or Earphone							
	Click-Air (dBnHL)	Click Bone (dBnHL)	500Hz (nHL/HL)	1000Hz (nHL/HL)	2000Hz (nHL/HL)	4000Hz (nHL/HL)	Live Voice (dBnHL/HL)
Right Ear							
Left Ear							

Check if normal hearing Left Right OR indicate loss below
Degree/Type of Loss: Left _____ Right: _____
Comments:

Child's Last Name: _____
 Child's First Name: _____
 Birthdate: _____

Date: _____

Follow-up Log:

***** At any point that contact is made with the family, drop down to schedule appointment**

Attempt to contact the family by phone:

<p>If no answering machine</p> <p>1. Document 3 phone attempts (on different days and times)</p> <p>2. If no contact after 14 days: ⇒ report to DHS / HCP (and Referral source if different) DHS will attempt to contact family by letter at last known address.</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%; text-align: center;">Date</th> <th style="width: 10%; text-align: center;">Time</th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td>Phone call 1</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td rowspan="3" style="font-size: 3em; vertical-align: middle;">}</td> </tr> <tr> <td>Phone call 2</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Phone call 3</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="3">.....Wait 14 days from last call</td> <td rowspan="2" style="vertical-align: middle;">If contact is made</td> </tr> <tr> <td colspan="3">Send this Reporting Form to DHS</td> </tr> </tbody> </table>		Date	Time		Phone call 1	_____	_____	}	Phone call 2	_____	_____	Phone call 3	_____	_____Wait 14 days from last call			If contact is made	Send this Reporting Form to DHS		
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<p>If answering machine is present</p> <p>1. Leave 2 messages 5 days apart</p> <p>2. If no response after 14 days: ⇒ report to DHS / HCP (and Referral source if different). DHS will attempt to contact family by letter at last known address.</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%; text-align: center;">Date</th> <th style="width: 10%; text-align: center;">Time</th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td>Phone call 1</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td rowspan="2" style="font-size: 3em; vertical-align: middle;">}</td> </tr> <tr> <td colspan="3">.....wait 5 days....</td> </tr> <tr> <td>Phone call 2</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td rowspan="2" style="vertical-align: middle;">If contact is made</td> </tr> <tr> <td colspan="3">.....wait 14 days from last call</td> </tr> <tr> <td colspan="3">Send this Reporting Form to DHS</td> </tr> </tbody> </table>		Date	Time		Phone call 1	_____	_____	}wait 5 days....			Phone call 2	_____	_____	If contact is madewait 14 days from last call			Send this Reporting Form to DHS		
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<p>If no phone/ or disconnected:</p> <p>1. Send letter to known address</p> <p>2. If no response after 10 days: ⇒ Verify address with healthcare provider</p> <p style="margin-left: 20px;">a. If same ⇒ report to DHS / HCP</p> <p style="margin-left: 20px;">b. If different ⇒ send new letter</p> <p>3. If no response after 14 days: ⇒ report to DHS / HCP (and Referral source if different). DHS will attempt to locate family.</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Date</th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td>Letter sent</td> <td style="text-align: center;">_____</td> <td rowspan="3" style="font-size: 3em; vertical-align: middle;">}</td> </tr> <tr> <td colspan="2">..... wait 10 days.....</td> </tr> <tr> <td colspan="2">Address verified with provider _____</td> </tr> <tr> <td colspan="2">Same - Send this Reporting Form to DHS</td> <td rowspan="2" style="vertical-align: middle;">If contact is made</td> </tr> <tr> <td colspan="2">Different – Letter sent to new address</td> </tr> <tr> <td colspan="2">.....wait 10 more days....</td> </tr> <tr> <td colspan="3">Send this Reporting Form to DHS</td> </tr> </tbody> </table>		Date		Letter sent	_____	} wait 10 days.....		Address verified with provider _____		Same - Send this Reporting Form to DHS		If contact is made	Different – Letter sent to new address	wait 10 more days....		Send this Reporting Form to DHS			
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<p>When contact is made (either directly, response to your calls or DHS letter)</p> <p>1. Schedule the diagnostic evaluation (before 3 months of age if possible)</p> <p>2. If family refuses: ⇒ Report to DHS / HCP</p>	<p>Appointment scheduled for _____</p> <p>.... Report after appointment</p> <p>Parent refused evaluation _____</p> <p>.... Send this Reporting Form to DHS</p>																					

MAIL or FAX this FORM TO:

EHDI PROGRAM
 Office of Family Health
 800 NE Oregon Ste.805
 Portland, OR 97232

Fax: (971) 673-0251

Questions on filling out this form?
 Call David Laszlo, 541-382-2646

RISK FACTOR CODES

F – Family history of congenital, permanent hearing loss
 N- >48 hour admission to NICU
 O- Ototoxic medications administered
 H- Hyperbilirubinemia with transfusion
 S- Syndrome associated with hearing loss
 C- Cranio-facial anomaly or defect of head or neck region
 V – 3 or more days of mechanical ventilation
 D- neuroDegenerative disorder
 B- Bronchio-pulmonary dysplasia
 A- Ashyxia M – Meningitis U - In-utero infection