



Tennessee Department of Health
Newborn Hearing Screening Program
 Women's Health and Genetics, Newborn Hearing Screening
 Laboratory Services, 630 Hart Lane, Nashville, Tennessee 37243
 615-262-6160 Fax 615-262-6159

Report of Infant Hearing Re-Screen or Diagnostic Evaluation

Child's Last Name _____ First Name _____ Middle Name _____ Sex _____ Birth Date _____

Mother's Last Name _____ First Name _____ Mother's Maiden Name _____ State Lab TDH# (if available) _____

Address _____ City _____ State/Zip _____ Phone _____

Referred by: Hospital Screening pass refer Name of Hospital _____

Other Specify _____

Out of State _____

Date of Evaluation: _____ Initial Screen Re-screen Diagnostic 3 mo. F/U 6 mo. F/U

Risk Indicators for Hearing Loss: _____

Type(s) of Evaluation: ABR OAE TEOAE DPOAE ASSR Tympanometry Behavioral Testing

Degree of Hearing Loss:	Ear	Referrals:	Date
Hearing Within Normal Limits	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> No Referral	_____
Mild (21-40 dB HL)	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Repeat Hearing Testing	_____
Moderate (41-70 dB HL)	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Primary Care Provider (PCP)	_____
Severe (71-90 dB HL)	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Medical Specialist (ENT/OTO)	_____
Profound (>90 dB HL)	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Early Intervention Program	_____
Sloping Hearing Loss	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> TEIS <input type="checkbox"/> Other _____	_____
Unspecified Hearing Loss	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Children's Special Services (CSS)	_____
Inconclusive due to: _____		<input type="checkbox"/> Speech/Language Services	_____
		<input type="checkbox"/> Hearing Aid Fitting	_____
		<input type="checkbox"/> Genetic Referral	_____
		<input type="checkbox"/> Family Support/Family Voices	_____
		<input type="checkbox"/> Vision Referral	_____
		<input type="checkbox"/> Other _____	_____

Type of Hearing Loss:	Ear	Type and Location
Hearing Within Normal Limits	<input type="checkbox"/> R <input type="checkbox"/> L	
Fluctuating Conductive HL	<input type="checkbox"/> R <input type="checkbox"/> L	
Permanent Conductive HL	<input type="checkbox"/> R <input type="checkbox"/> L	
Sensorineural Hearing Loss	<input type="checkbox"/> R <input type="checkbox"/> L	
Auditory Neuropathy/Dyssynch	<input type="checkbox"/> R <input type="checkbox"/> L	
Mixed Hearing Loss	<input type="checkbox"/> R <input type="checkbox"/> L	
Unspecified Hearing Loss	<input type="checkbox"/> R <input type="checkbox"/> L	
Inconclusive due to: _____		

Follow-up date: _____

Comments: _____

Provider: _____ Phone: (____) _____
 Audiologist, Medical Provider, Hospital, Early Intervention Provider, Other

Address: _____

City: _____ State/Zip: _____

Mail to above address or **Fax to 615-262-6159** Attn: Newborn Hearing Coordinator

