Newborn Hearing Screening Results

Baby's Name: _____ Date of Birth: _____

Hospital or location of baby's birth: _____

Screening agency or site where this test was completed:

Agency: _____ Address: _____

Screener: _____ Phone: _____

_____**Initial Screening** _____**Follow-up Screening**

Technology: _____ TEOAE _____ DPOAE _____ AABR _____ABR

Date of Testing: _____

Screening Results:

Right Ear: _____ PASS _____ REFER **Left Ear**: _____ PASS _____ REFER

Recommendations: _____

Referred to: _____ Date: _____

Parent or Guardian Contact Information:

Name: _____Address:_____

Phone: _____ _____

Baby's Primary Care Provider:

Name : _____Phone: _____

I hereby give my permission to staff at the above-named agency or site to release hearing screening results to the hospital where my baby was born and to the Utah Department of Health. I understand that newborn hearing screening is required by law, and must be reported to the Utah Department of Health. The information will be used to ensure that appropriate referral and follow-up services, when necessary, are made available to my child. I understand that this information will not be shared with unauthorized people.

_____

Signature of Parent Date

To the screening agency: Please complete this entire form and return copies to the **birthing hospital** listed, in care of the Newborn Nursery Hearing Screening Coordinator, **AND** to the:

Utah Department of Health
Early Hearing Detection and Intervention
PO Box 144620
Salt Lake City, UT 84114-4620

Fax: (801) 536-0492

Phone: (801) 273-6600

DISTRIBUTION: Yellow: Parent, White: Utah Department of Health, Blue: Birthing Hospital, Pink: Infant's Medical Record 10/2020