PHYSICIAN OFFICE HEARING RESCREEN REPORT

FOR INFANTS WHO REFERRED ON THEIR NEWBORN HEARING SCREEN

FILL OUT AND FAX TO EHDI AT: 775-688-2984

NAME OF CHILD: _____ BIRTHDATE: _____ GENDER: MALE / FEMALE

BIRTH HOSPITAL: _____ MOTHER'S LAST NAME AT BABY'S BIRTH: _____

PARENT/GUARDIAN NAMES: _____

ADDRESS WITH CITY & ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ CONTACT PHONE: _____

DATE OF HEARING RESCREEN: _____ **LOCATION:** _____

TYPE OF HEARING RESCREEN:

- ☐ OAE SCREEN
- ☐ OTHER: _____

RESULTS:

RIGHT	LEFT	
☐	☐	PASS – SUGGESTS NORMAL HEARING
☐	☐	REFER/FAIL – POSSIBLE HEARING LOSS

OTHER DISABILITIES/CONCERNS: _____

RECOMMENDATIONS AND REFERRALS:

- ☐ Recs: _____
- ☐ ENT Referral to: _____
- ☐ Audiology Referral to: _____
- ☐ NV Early Intervention Services Referral for: ☐ Audiological Assessment ☐ Developmental Assessment

Physician's Name: _____ Group Name: _____.

Address: _____ Phone: _____.

Date report faxed to EHDI Program (see below): _____.

Please fax along with screening printout within 48 hours to: 775-688-2984

Nevada Early Hearing Detection and Intervention (EHDI) Program
Infant Data and Follow-up Coordinator
Phone: 775-688-0382