

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
NEWBORN HEARING SCREENING
AUDIOLOGY FOLLOW-UP SERVICES REPORT**

CHILD'S NAME: _____ Med.ID: _____

NAME BABY MAY ALSO BE KNOWN AS: _____

DATE OF BIRTH: _____ SEX: M F

WHAT HOSPITAL WAS THIS BABY BORN IN? _____
Birth hospital is extremely important to answer

MOTHERS NAME: _____
(Last) (First) (MI) (Maiden)

GUARDIAN'S NAME: _____
(If different than mother)

ADDRESS: _____
(Street) (Apt. #)

(City) (State) (Zip)

(County) (Phone)

DIAGNOSIS:	RIGHT	LEFT
Hearing Within Normal Limits		
Sensorineural Hearing Loss		
Conductive Hearing Loss		
Mixed Hearing Loss		
Undetermined Type Hearing Loss		

DEGREE OF HEARING LOSS:	RIGHT	LEFT
Mild Hearing Loss		
Moderate Hearing Loss		
Severe Hearing Loss		
Profound Hearing Loss		

Sloping Hearing Loss: Describe per ear:	_____	_____
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DATE OF THIS EVALUATION: _____ DATE AIDED: _____
(If applicable)

IS THERE A FAMILY HISTORY OF CONGENITAL HEARING LOSS? _____

LIST ANY KNOWN RISK FACTORS FOR HEARING IMPAIRMENT: _____

(Two Sided)

RECOMMENDATIONS/REFERRALS	DATE REFERRED
Pass with High Risk Monitoring ___ 3mo. ___ 6mo. ___ 1Yr	
Early Intervention Services (EI)	
Division of Specialized Care for Children (DSCC)	
Medical Referral	
Repeat Diagnostic Hearing Testing	
Hearing Instrument Fitting	
None	
Other: (Specify)	

(Mark all that apply): completed = **X** ordered =)

SCREENING TOOL: DIAGNOSTIC TESTS:

DPOAE: _____ Physical exam, review of medical records _____

TEOAE: _____ ABR _____

Automated ABR _____ DPOAE _____ TEOAE _____

 Acoustic Immittance Measures _____

Other _____ Laboratory studies _____

 Radiology _____ Genetic evaluation _____

 Other: (Specify) _____

NOTES: _____

Audiologist: (full name) _____

Facility/ Agency: _____

Address _____ City _____ State _____ Zip _____

Phone: (____) _____ Reporting date: _____

Infants Primary Health care Provider: _____

Address _____ City _____ State _____ Zip _____

Phone: (____) _____

Please submit this form to:

Newborn Hearing Screening Program
 Illinois Department of Public Health
 500 East Monroe Street, First Floor
 Springfield, IL 62701

Or, form may be faxed to fax number (217) 557-5324