



# AUDIOLOGICAL FOLLOW –UP REPORTING FORM

FOR CHILDREN 0-3 YEARS OLD WHO DID NOT PASS THE NEWBORN HEARING SCREEN  
OR HAVE DELAYED ONSET HEARING LOSS

**EMAIL to [nvehdi@health.nv.gov](mailto:nvehdi@health.nv.gov) or Submit to EHDI Data Portal**

NAME OF CHILD: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ GENDER: MALE  / FEMALE

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BIRTH HOSPITAL: \_\_\_\_\_ MOTHER'S LANGUAGE (IF NOT ENGLISH): \_\_\_\_\_

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MOTHER'S FIRST AND LAST NAME: \_\_\_\_\_

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FATHER'S FIRST AND LAST NAME: \_\_\_\_\_

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ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

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HOME PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

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EMERGENCY CONTACT: \_\_\_\_\_ CONTACT PHONE: \_\_\_\_\_

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BABY'S PRIMARY CARE PHYSICIAN : \_\_\_\_\_

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**TESTING THAT DETERMINED HEARING LEVELS (MARK ALL THAT APPLY)**

<p><b>ABR:</b></p> <input type="checkbox"/> CLICKS <input type="checkbox"/> TONE BURSTS/PIPS <input type="checkbox"/> BONE CONDUCTION	<p><b>OAE TEST RESULTS:</b></p> <table border="0"> <tr> <td style="text-align: center;">RIGHT</td> <td style="text-align: center;">LEFT</td> </tr> <tr> <td><input type="checkbox"/> NORMAL</td> <td><input type="checkbox"/> NORMAL</td> </tr> <tr> <td><input type="checkbox"/> ABNORMAL</td> <td><input type="checkbox"/> ABNORMAL</td> </tr> </table>	RIGHT	LEFT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	<input type="checkbox"/> ABNORMAL	<p><b>BEHAVIORAL:</b></p> <input type="checkbox"/> VRA <input type="checkbox"/> BOA <input type="checkbox"/> CPA	<p><b>TYMPS:</b></p> <table border="0"> <tr> <td style="text-align: center;">RIGHT</td> <td style="text-align: center;">LEFT</td> </tr> <tr> <td><input type="checkbox"/> NORMAL</td> <td><input type="checkbox"/> NORMAL</td> </tr> <tr> <td><input type="checkbox"/> ABNORMAL</td> <td><input type="checkbox"/> ABNORMAL</td> </tr> </table>	RIGHT	LEFT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	<input type="checkbox"/> ABNORMAL
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RIGHT	LEFT														
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<input type="checkbox"/> ABNORMAL	<input type="checkbox"/> ABNORMAL														

**HEARING LEVELS BASED ON PTA**

RIGHT	LEFT
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**TYPE OF HEARING LOSS:**

RIGHT	LEFT
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**RISK FACTORS:**

INFECTION  
 PREMATURE BIRTH  
 DRUG/ALCOHOL USE  
 ANOXIA  
 GENETICS  
 FAMILY HISTORY  
 AURAL ATRESIA/MICROTIA  
 OTHER: \_\_\_\_\_

**COMMENTS AND RECOMMENDATIONS:**

Additional hearing testing has been scheduled on: \_\_\_\_\_  
 Child has been referred to: \_\_\_\_\_  
 Per IDEA federal law, child was referred to Nevada Early Intervention Services due to new diagnosis of permanent hearing loss.  
 Child is already receiving early intervention services

DATE OF EXAM: \_\_\_\_\_ DATE SENT: \_\_\_\_\_

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AUDIOLOGIST: \_\_\_\_\_ OFFICE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

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Nevada Division of Public and Behavioral Health

**Nevada Early Hearing Detection and Intervention (EHDI)**

4150 Technology Way, Suite 210, Carson City, NV 89706

Phone: 775-684-4239; Email: [nvehdi@health.nv.gov](mailto:nvehdi@health.nv.gov)

<http://dpbh.nv.gov/Programs/EHDI/EHDI-Home/>