



HEARING SCREENING REPORTING FORM

FOR CHILDREN 0-3 YEARS OLD WHO NEED AN OUT PATIENT HEARING
SCREEN

EMAIL to nvehdi@health.nv.gov or Submit to EHDI Data Portal

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

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

MOTHER'S FIRST AND LAST NAME: _____

FATHER'S FIRST AND LAST NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ EMAIL: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ CONTACT PHONE: _____

BABY'S PRIMARY CARE PHYSICIAN : _____

DATE OF HEARING SCREEN: _____ **LOCATION:** _____

TYPE OF HEARING SCREEN:

- OAE SCREEN
 AABR

RESULTS:

- | | | |
|--------------------------|--------------------------|------------------------------------|
| RIGHT | LEFT | |
| <input type="checkbox"/> | <input type="checkbox"/> | PASS – SUGGESTS NORMAL HEARING |
| <input type="checkbox"/> | <input type="checkbox"/> | REFER/FAIL – POSSIBLE HEARING LOSS |

LIST ANY EAR ISSUES/MALFORMATIONS: _____

RECOMMENDATIONS AND REFERRALS:

- None
 Return for Recheck on: _____
 ENT Referral to: _____
 Audiology Referral to: _____
 NV Early Intervention Services Referral for: Audiological Assessment
 Developmental Assessment

DATE OF EXAM: _____ DATE SENT: _____

AUDIOLOGIST: _____ OFFICE NAME: _____ PHONE: _____

Nevada Division of Public and Behavioral Health
Nevada Early Hearing Detection and Intervention (EHDI)

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