DEPARTMENT OF HEALTH

NEWBORN HEARING SCREENING OUTPATIENT FOLLOW-UP REPORT FORM

OUTPATIENT SCREENING • APPOINTMENT CHANGE • REFERRALS

Fax completed form to MDH Newborn Screening at 651-215-6285

PATIENT INFORMATION

Child's Name (Last, First)	Date of Birth	Gender: ◯ Female ◯ Male
Address, City, State		
Mother's Name (Last, First)	Mother's Phone	
Caregiver's Name/Relationship/Phone (if different)		Language Used in Home
Primary Care Physician	**Primary Clinic Name, City**	

APPOINTMENT CHANGE

Date of Appointment	☐ Cancelled	☐ Did Not Show	**New Appointment Date:**

ASSESSMENT RESULTS

IMPORTANT: DO NOT DELAY COMPLETE AUDIOLOGICAL DIAGNOSIS DUE TO MIDDLE EAR FLUID

Date of Service	**First Outpatient Visit?**	◯ Yes ◯ No
Audiologist	**Clinic Name, City**	

SCREENING RESULTS ✓ ALL THAT APPLY	RIGHT EAR	LEFT EAR
☐ AABR (screening)	◯ Pass ◯ Refer ◯ Not Done	◯ Pass ◯ Refer ◯ Not Done
☐ DPOAE	◯ Pass ◯ Refer ◯ Not Done	◯ Pass ◯ Refer ◯ Not Done
☐ TEOAE	◯ Pass ◯ Refer ◯ Not Done	◯ Pass ◯ Refer ◯ Not Done
Tympanometry ☐ 226 Hz ☐ 1000 Hz	◯ Peak ◯ No Peak ◯ Rounded ◯ Large Volume	◯ Peak ◯ No Peak ◯ Rounded ◯ Large Volume

*If result is REFER for one or both ears, schedule a diagnostic audiology appointment as soon as possible

REFERRALS AND APPOINTMENTS

✓ CHECK ALL THAT APPLY IF KNOWN

☐ Audiology	Clinic Referred To:	Appointment Date
☐ Otolaryngology	Clinic Referred To:	Appointment Date

NOTES

For more information on reporting, please contact newbornhearing@state.mn.us

REV: 10/2017