

NEWBORN HEARING SCREENING OUTPATIENT FOLLOW-UP REPORT FORM

OUTPATIENT SCREENING
APPOINTMENT CHANGE
REFERRALS
PATIENT INFORMATION

Child's Name (Last, First):	Date of Birth:	Gender Assigned at Birth:	Female
Address, City, State:		Male	
Mother/Parent's Name (Last, First):		Phone:	
Caregiver's Name/Relationship/Phone (if different):		Language Used in Home:	
Primary Care Physician:	Primary Clinic Name, City:		
If not MN birth, include birth hospital or home birth city/state:			

APPOINTMENT CHANGE

Date of Appointment:	Cancelled	Did Not Show	New Appointment Date:
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TEST RESULTS
IMPORTANT:

DO NOT DELAY COMPLETE AUDIOLOGICAL DIAGNOSIS DUE TO MIDDLE EAR FLUID

Date of Service:	First Outpatient Visit?	Yes	No
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Audiologist:	Clinic Name, City:
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SCREENING RESULTS	✓ ALL THAT APPLY	RIGHT EAR			LEFT EAR		
		Pass	Refer	Not Done	Pass	Refer	Not Done
	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	Peak		No Peak	Peak		No Peak
	226 Hz 1000 Hz	Rounded		Large Volume	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

FAX COMPLETED FORM TO NEWBORN SCREENING (651) 215-6285