

**Virginia Early Hearing Detection & Intervention Program**

**Hospital Hearing Screening Reporting Form**

 **( Use as directed by VDH ONLY for Infants transferred from Out of State )**

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|  **A** 🡺 **Infant Information: Date of Birth:**  \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ ( MM / DD / YYYY ) |
|  Infant’s LAST Name:  | FIRST Name:  | MIDDLE Name: Gender:  |
|  Reporting Facility:  | Date of Discharge \_\_/\_\_/ \_\_\_\_\_\_ | Birth Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  **B** 🡺 **Primary Contact: Relationship to Infant:** \_\_\_\_MOTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Contact’s LAST Name:  | FIRST Name:  | MIDDLE Name:  | Maiden Name: |
|  Street Address:  | City:  | State:  | Zip:  |
|  Phone Number: ( )  | Primary Language: |  |

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|  **C** 🡺 **Infant’s Primary Medical Care Provider: Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  Provider’s LAST Name:  | FIRST Name: | Phone:  |
|  Street Address: | City: State: | Zip: |
|  **D** 🡺 **Screening Results: Date of Screening**  \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ ( MM / DD / YYYY ) |
|  Test: |  **🞏** ABR **□** Automated ABR |  **□** DPOAE **□** Automated DPOAE |  **□** TEOAE **□** Automated TEOAE |  |
| Right Ear |  | Left Ear |
|  **🞏** Pass |  **□** Pass with Risk  |  **□** Fail |  **□** Missed |  |  **🞏** Pass |  **□** Pass with Risk  |  **□** Fail |  **□** Missed |

##### Risk Indicators for Progressive or Delayed-Onset Sensorineural and/or Conductive Hearing Loss

1. Family History of permanent childhood hearing loss :

**□** Mother of child **□** Father of child **□** Brother of child **□** Sister of child **□** Grandfather of child **□** Grandmother of child

**□** Aunt of child **□** Uncle of child **□** 1st cousin of child **□** More than one relative of the same parent

2. Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or Eustachian tube dysfunction :

**□** Branchio-oto-renal (BOR) **□** CHARGE association **□** Goldenhar (oculo-auriculo-vertebral or OAV) **□** Noonan **□** Pierre Robin

**□** Rubenstein-Taybi **□** Stickler  **□** Trisomy 21  **□** Trisomy 18  **□** Trisomy 13  **□** Trisomy 9  **□** Trisomy 8 **□** Williams **□** Zellweger

3. Postnatal infections associated with sensorineural hearing loss : **□** Confirmed Bacterial meningitis   **□** Confirmed Viral meningitis

4. In utero infections : **□** Cytomegalovirus **□** Herpes **□** Rubella **□** Syphilis **□** Toxoplasmosis

5. NEONATAL INDICATORS : **□**  Intensive care greater than (>) 5 days **□** Extracorporeal membrane oxygenation (ECMO)  **□** Assisted ventilation

 **□**  Exposure to ototoxic medications **□** Hyperbilirubinemia requiring exchange transfusion

6. Syndromes associated with progressive hearing loss such as : **□** Neurofibromatosis  **□** Osteopetrosis  **□** Usher **□** Jervell **□** White Forelock

 **□** Alport **□** Waardenburg **□** Pendred **□** Lange-Nielson

7. Neurodegenerative disorders, such as : **□** Hunter syndrome **□** Friedreich's ataxia **□** Charcot-Marie-Tooth syndrome

8. Head Trauma requiring hospitalization : **□** Basil Skull/Temporal Bone Fracture **□** Other - specify if chosen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Parental or caregiver concern regarding hearing, speech, language, and or developmental delay :  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Craniofacial Anomalies : **□** Pinna **□** Temporal Bone anomalies **□** Atresia of the ear **□** Choanal Atresia  **□** Microtia **□** Cleft palate

11. Chemotherapy : **□** Toxic chemotherapy **□** Other - specify if chosen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return form to: VDH, Virginia EHDI Program, P.O. Box 2448, Richmond, VA 23218 or Fax to 864-7771**