

**Virginia Early Hearing Detection and Intervention Program
2016 Hospital Annual Reporting Form**

The Hospital Newborn Hearing Program Supervisor should complete this form and return it to VDH no later than August 31, 2016. In addition, the supervisor should review the list of currently authorized VISITS hearing users and notify the EHDI program (804-864-8199 or 804-864-7713) of individuals no longer employed or no longer requiring VISITS access.

General Hospital Information:

A. Hospital Name: _____
Hospital CEO Name/Chief Administrator Name: _____
Director of Nursery (or unit in which Newborn Screening operates): _____
Contact Mailing Address and Physical Address if different: _____

Number of births in 2015: _____

B. Does the hospital operate a newborn nursery? YES NO
Does the hospital have a Neonatal Intensive Care Unit (NICU)? YES NO
If a NICU facility, what level of care is provided? Level 1 Level 2 Level 3 Level 4

Newborn Hearing Screening Program:

A. Name of Coordinator: _____ Phone Number: _____
Fax Number: _____ Email: _____
Mailing Address (please include necessary floor or unit) & Physical Address if different: _____

Is the coordinator a hospital contractor? YES NO If YES :
Contracting Company Name _____ Contractor Supervisor Name: _____

B. Name of Coordinator's Hospital Supervisor: (If coordinator is a contractor this must be the name of the direct hospital employee overseeing the program or contract): _____
Phone Number: _____
Fax Number: _____ Email: _____
Mailing Address (please include necessary floor or unit) & Physical Address if different: _____

VISITS-Hearing Users:

A. Name of *Primary* User: _____ Phone Number: _____
Fax Number: _____ Email Address: _____
Mailing Address (please include necessary floor or unit) & Physical Address if different: _____

B. Name of *Secondary* User: _____ Phone Number: _____
Fax Number: _____ Email Address: _____
Mailing Address (please include necessary floor or unit) & Physical Address if different: _____

C. Location of computer used for VISITS data entry:
 Hospital Offsite hospital office (such as contractor's office) Home Office
 Other (Please specify): _____

D. Ownership of computer used for VISITS data entry:
 Hospital owned Contractor owned Personal computer

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Advising Audiologist to Hospital Newborn Hearing Screening Program:

A. Does the hospital's newborn hearing screening program have an advising audiologist? Yes No

B. Name of Advising Audiologist: _____ Facility Name: _____
Phone Number: _____ Fax Number: _____ Email: _____
Address: _____

Screening Program Information:

A. What screening equipment do you use in the well-baby nursery?

OAE ABR Other: _____

When was your screening equipment last calibrated? _____ (mm/dd/yy)

B. What screening equipment do you use in the NICU (if applicable)?

OAE ABR Other: _____

When was your screening equipment last calibrated? _____ (mm/dd/yy)

C. If a newborn fails the first screening, does your hospital re-screen the newborn before discharge? YES NO

If YES, how many times will you screen the baby before referring the baby for follow-up?

1-2 3-4 4-5 6+

D. Does your hospital distribute the "Can Your Baby Hear" brochure? YES NO

E. How do you collect risk factor information? (Check all that apply)

Direct query to parent Parents given checklist to check off Review of medical record

Other (please describe) _____

F. Does your hospital utilize the *Loss & Found* Video for patient education? YES NO

G. Does your hospital utilize the NCHAM Newborn Hearing Screening training Curriculum

(<http://www.infanthearing.org/nhstc/index.html>) to train your hearing screeners?

YES NO If NO, how do hearing screeners get trained? _____

H. Does your hospital perform outpatient re-screenings? YES NO

I. Does your hospital schedule follow-up appointments prior to discharge? YES NO

J. Does your hospital perform outpatient diagnostic audiological evaluations? YES NO

If YES, who is the contact? _____

K. Does your hospital have an EMR (Electronic Medical Record) System? YES NO

If YES, provide name of EMR system _____

Verification:

As the supervisor of the Newborn Hearing Screening program at this hospital, I verify that this information is accurate and true to the best of my knowledge.

Signature: _____ Printed Name: _____ Date: _____

(Newborn Hearing Screening Program Supervisor – Hospital Employee)

Return no later than August 31, 2016 to:
Virginia Early Hearing Detection and Intervention Program
109 Governor Street, 9th floor Richmond, VA 23219-3623
Phone: 804-864-8199 or 804-864-7713
Email: Kristen.yates@vdh.virginia.gov
<http://www.vahealth.org/hearing/>
