

**Virginia Early Hearing Detection & Intervention Program**

**Hospital Hearing Screening Reporting Form**

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**