

Michigan Department of Community Health
 Early Hearing Detection and Intervention Program (MDCH/EHDI)
 Audiological/Medical Follow-up Services Report

Child's Last Name: _____ Last Name at Birth: _____
 First Name: _____ Birth Date: _____ Kit #: _____
 Hospital of Birth: _____ Male Female Twin: A B
 Parent's Last Name: _____ First Name: _____
 Address: _____ Phone: (_____) _____
 City: _____ State: _____ ZIP: _____

Screening Results

Date: _____
 Type of Screen: AABR DPOAE TEOAE ABR Risk factor(s) for hearing loss? Yes No Unknown
 Referral to audiological diagnostic? Yes No
 Results: RE Pass Fail/Refer Date audiological evaluation scheduled: _____
 LE Pass Fail/Refer

Diagnostic Audiological Results

DATE: _____
 Type of Test: OAE Immittance
 ABR-click ABR-toneburst ABR-bone
 Results:
 RE LE
 Within Normal Limits
 Sensorineural (SN)
 Undetermined HL— Sensorineural not ruled out
 Conductive (possibly transient), SN ruled out
 Conductive (atresia, anotia, etc.), SN ruled out
 Mixed
 Auditory Dys-synchronous
 Mild
 Moderate
 Severe
 Profound
 Special Care/NICU? Yes No
 Risk factor(s) for HL? Yes No Unknown
 Acquired HL? Yes No Unknown
 Etiology (if known): _____
 Recommendations:
 Medical Eval. Ref. Yes No Date: _____
 Repeat Hearing Eval. Yes No Date: _____
 Early On Referral Yes No Date: _____
 CSHCS Referral Yes No Date: _____
 Genetic Referral Yes No Date: _____
 Hearing Aid Eval. Yes No Date: _____
 Sp/Lang. Ref. Yes No Date: _____
 Ophthalmology Ref. Yes No Date: _____
 Primary Health Provider: _____
 Phone: (_____) _____

Referral to the Guide By Your Side (Parent to Parent Home Visitation Program) Yes No (start date 1/05)

I give my permission to release diagnostic audiological/medical evaluation results to my primary care physician and the Michigan Department of Community Health (MDCH) Early Hearing Detection and Intervention (EHDI) Program, The Michigan Department of Education (MDE), *Early On* Michigan, and Children's Special Health Care Services. Other collaborating MDCH programs also have my permission to assist with coordination of follow-up on behalf of my child. Diagnostic, follow-up, and intervention information can be sent to MDCH from participating agencies. Information will not be shared with unauthorized people or agencies not involved in hearing screening follow-up and/or intervention in conjunction with the MDCH Program.

Signature of Parent/Guardian: _____ Date: _____

Assessment Site Information

Test performed by: _____ Site Name: _____
 Phone: (_____) _____ FAX: (_____) _____

Under HIPAA (164.512 (b) THE PUBLIC HEALTH EXCEPTION

- Covered entities may disclose data to Public Health Authorities for use in public health activities.
- Covered entities that are also Public Health Authorities may use data for public health activities.
- Authorization from patients is not required for these uses and disclosures.

FAX To: (517) 335-8036

Telephone: (517) 335-8884
 Mailing Address: MDCH/EHDI P.O. Box 30199
 Lansing, MI 48909