

**Early Hearing Detection and Intervention (EHDI) Program
Audiological/Medical Follow-up Services Report
Fax To: (517) 335-8036**

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

Screening Results

Date: _____ Type of Screen: AABR DPOAE TEOAE ABR

Results: **Right Ear** Pass Fail/Refer **Left Ear** Pass Fail/Refer

Date audiological evaluation scheduled: _____ Where: _____

Diagnostic Audiological Results

Date: _____ Type of Test: OAE Immittance ABR-click ABR-toneburst ABR-bone

Results: (Check one type and degree for each ear.)

Right	Left	Type	Right	Left	Degree
		Within Normal Limits			Slight (16-25 dB)
		Sensorineural (SN)			Mild (26-40 dB)
		Undetermined HL- SN not ruled out			Moderate (41-55 dB)
		Conductive (possibly transient), SN ruled out			Moderately - Severe (56-70 dB)
		Conductive (atresia, anotia, etc.), SN ruled out			Severe (71-90 dB)
		Mixed			Profound (>90 dB)
		Auditory Neuropathy			

Other Information: (Complete as much as possible)

Etiology:			
	Yes	No	Unknown
Special Care/NICU			
Risk Factors for HL			
Indicate date of following appointments:			Unscheduled
Medical Evaluation			
Repeat Hearing Evaluation			
Hearing Aid Evaluation			

Please indicate whether referrals have been made for the following:	Yes	No
CSHCS		
Early On		
Speech and Language		
Genetics		
Ophthalmology		

Referral to the Guide By Your Side (Parent to Parent Support Program) Yes No

I give my permission to release diagnostic audiological 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 may 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: (_____) _____