

HEARING SCREENING LOG SHEET

Patient Information Here to include: Name, D.O.B., Midwife (or printed label)	Date of Screen	Right Ear Result	Left Ear Result	Screener Initials	Birth Screen Notification Completed ✓ box	**Follow-up Appt. for Hearing Re-Screening Date /Time & Results	Re-Screen Notification Completed ✓ box
Name: D.O.B: Midwife:					MDCH <input type="checkbox"/> Newborn Screening Specimen Card Parent <input type="checkbox"/>	Date: _____ Time: _____ RE Result: _____ LE Result: _____ Screener: _____	PCP <input type="checkbox"/> MDCH <input type="checkbox"/> Parent <input type="checkbox"/>
Name: D.O.B: Midwife:					MDCH <input type="checkbox"/> Newborn Screening Specimen Card Parent <input type="checkbox"/>	Date: _____ Time: _____ RE Result: _____ LE Result: _____ Screener: _____	PCP <input type="checkbox"/> MDCH <input type="checkbox"/> Parent <input type="checkbox"/>
Name: D.O.B: Midwife:					MDCH <input type="checkbox"/> Newborn Screening Specimen Card Parent <input type="checkbox"/>	Date: _____ Time: _____ RE Result: _____ LE Result: _____ Screener: _____	PCP <input type="checkbox"/> MDCH <input type="checkbox"/> Parent <input type="checkbox"/>
Name: D.O.B: Midwife:					MDCH <input type="checkbox"/> Newborn Screening Specimen Card Parent <input type="checkbox"/>	Date: _____ Time: _____ RE Result: _____ LE Result: _____ Screener: _____	PCP <input type="checkbox"/> MDCH <input type="checkbox"/> Parent <input type="checkbox"/>

**** If REFER/FAIL Birth Hearing Screen – Schedule follow-up Hearing Re-screen Appt. within 2weeks**
Report birth hearing results on the MI Dept. of Community Health/EHDI Newborn Screening Specimen Card within 7 days of initial screen.
Report Hearing Re-Screen results to MI Dept. Of Health via fax 517-335-8036 within 7 days of re-screen.