Hearing Screening Form
Early Hearing Detection and Intervention Program
Fax to 517-763-0183. Send Hearing Screen Card to EHDI.

Newborn Information

Newborn's Name: _____ ☐Male ☐Female

Twin: ☐A ☐B ☐C

Hospital of Birth: _____ Initial Screen Date: _____

Method: ☐ A-ABR ☐ ABR ☐OAE

Date of Birth: _____ Kit #_____ Results: Right Ear: ☐Pass ☐Refer

Left Ear: ☐Pass ☐Refer

Medical Record #:_____-

Parent/Guardian Contact Information

Mother's Name: _____

Address: _____

Phone #: (_____)_____ Alternate #: (_____)_____

Alternate Contact (Friend/relative/case worker/adoption agency)

Name: _____

Address: _____

Phone #: (_____)_____ Alternate #: (_____)_____

Referral Information

☐ Referral to primary care physician for follow-up Name: _____

Phone #: (_____)_____

☐ Referral for outpatient re-screening? Site name: _____

Phone #: (_____)_____ Date Scheduled: _____

Outpatient Screen Results

Date: _____

Method: ☐A-ABR ☐ ABR ☐DPOAE Date diagnostic hearing evaluation scheduled: _____

Results: Right Ear: ☐Pass ☐Refer Diagnostic Site Name:_____

Left Ear: ☐Pass ☐Refer

Parental/Guardian Permission

I give my permission to release referral results to my primary care physician and the Michigan Department of Health and Human Services Early Hearing Detection and Intervention (EHDI) Program. EHDI also has my permission to assist with coordination of follow-up on behalf of my child. Information will not be shared with unauthorized people or agencies not involved in hearing screening follow-up.

Signature of Parent/Guardian: _____Date: _____

Updated 4.2021