Early Hearing Detection and Intervention (EHDI) Program Reporting Form
Fax to 517-763-0183

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: □ A-ABR □ ABR □ DPOAE

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

Date audiological evaluation scheduled: _____ Where: _____

Diagnostic Audiological Results

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

Results: **Check one type and degree for each ear.**

Left	Right	Type	Left	Right	Degree
		Within Normal Limits			Slight (16-25 dB)
		Sensorineural (SN)			Mild (26-40 dB)
		Undetermined– 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:

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		

Early On Signed IFSP Date:_____

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 Health and Human Services (MDHHS) 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 MDHHS 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 MDHHS 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 MDHHS Program.

Signature of Parent/Guardian: _____ Date: _____

Assessment Site Information

Test performed by: _____ Site Name: _____

Phone: (_____) _____