DEPARTMENT OF HEALTH

NEWBORN HEARING SCREENING AUDIOLOGY FOLLOW-UP REPORT FORM

PATIENT INFORMATION

Child's Name (Last, First): _____ Date of Birth: _____ Gender at Birth: ☐ Female ☐ Male

Address, City, State: _____

Mother/Parent Name (Last, First): _____ Phone: _____

Caregiver's Name/Relationship/Phone (if different): _____ Language Used in Home: _____

Primary Care Physician: _____ Primary Clinic Name, City: _____

If not MN birth, **include birth hospital or home birth city/state**: _____

TEST RESULTS

IMPORTANT: test both ears & do not delay complete audiological diagnosis due to middle ear fluid

Date of Service: Audiologist: Clinic Name, City:

Screening or diagnostic results

✓ ALL THAT APPLY	RIGHT EAR	LEFT EAR
☐ AABR (screening)	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done
☐ DPOAE	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done
☐ TEOAE	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done	☐ Pass ☐ Refer ☐ Inconclusive ☐ Not Done
Tympanometry ☐ 226 Hz ☐ 1000 Hz	☐ Peak ☐ Rounded ☐ No Peak ☐ Lg. Volume	☐ Peak ☐ Rounded ☐ No Peak ☐ Lg. Volume
☐ Acoustic Reflex (Ipsi)	☐ Normal ☐ Elevated ☐ Absent	☐ Normal ☐ Elevated ☐ Absent

DIAGNOSIS

	Degree	Type	Degree	Type
☐ Click ABR	☐ Normal	☐ Normal	☐ Normal	☐ Normal
☐ Toneburst ABR	☐ Slight	☐ Sensorineural	☐ Slight	☐ Sensorineural
☐ Bone Conduction ABR	☐ Mild	☐ Perm. Conductive	☐ Mild	☐ Perm. Conductive
☐ ASSR	☐ Moderate	☐ Transient Cond.	☐ Moderate	☐ Transient Cond.
☐ Narrow Band Chirps	☐ Mod. Severe	☐ Mixed	☐ Mod. Severe	☐ Mixed
☐ Headphones/insert	☐ Severe	☐ ANSD	☐ Severe	☐ ANSD
☐ Non-ear specific VRA	☐ Profound	☐ Undetermined	☐ Profound	☐ Undetermined
☐ Sedated testing				

REFERRALS AND APPOINTMENTS

✓ CHECK ALL THAT APPLY IF KNOWN

☐ Audiology	Appointment Date:	☐ Amplification ☐ Loaner	Fit Date:
☐ Otolaryngology	Appointment Date:	☐ Genetic Evaluation	Appointment Date:
☐ Help Me Grow	Date of Referral:	☐ Ophthalmology	Appointment Date:
☐ Parent Support	Date of Referral:	☐ Other (specify):	

NOTES/APPOINTMENT CHANGE

FAX COMPLETED FORM AND COPY OF VISIT SUMMARY TO 651-215-6285

For more information, please contact health.newbornhearing@state.mn.us

REV 03/2022