

Infant's Name:

Infant's DOB:

Birth Parent's Name:

Screening Provider/Location:

Primary Care Physician (name/location):

<b>Hearing Screening Results</b>		
Date of Screening:		
Screening Provider/Location:		
Right Ear:	Pass	Refer
Left Ear:	Pass	Refer

<b>Hearing Rescreening Results</b>		
Date of Rescreening:		
Screening Provider/Location:		
Right Ear:	Pass	Refer
Left Ear:	Pass	Refer

If one or both ears do not pass the hearing rescreen, please indicate scheduled diagnostic appointment information (date and location) in the comments section.

<b>Pulse Oximetry (CCHD) Screening Results</b>		Date of Screening:
Screening Provider/Location:		
1st Screen Result:	2nd Screen Result:	3rd Screen Result:
Time of Screen:	Time of Screen:	Time of Screen:
Hand (Sat Value):	Hand (Sat Value):	Hand (Sat Value):
Foot (Sat Value):	Foot (Sat Value):	Foot (Sat Value):
Heart Rate:	Heart Rate:	Heart Rate:

\*The Minnesota Department of Health does not require the baby's heart rate.

Additional Comments:

FAX, email, or mail this result report to the Minnesota Department of Health within 48 hours of screening.

Send or fax completed form to:  
Minnesota Department of Health  
Newborn Screening Program  
P.O. Box 64899  
St. Paul, MN 55164-0899

Phone: (800) 664-7772  
Fax: (651) 215-6285  
Email: [newbornscreening@health.state.mn.us](mailto:newbornscreening@health.state.mn.us)  
Website: [www.health.state.mn.us/newbornscreening](http://www.health.state.mn.us/newbornscreening)  
REV Date: 3/2024