Submit completed Form 53 to the Early Hearing Detection and Intervention (EHDI) Program within 48 hours.

FORM 53 | HEARING DIAGNOSTIC REPORT| MISSISSIPPI

Child's Name: _____ Birth Name: _____ DOB: _____
Last, First *Last, First*

Mother's Name: _____ Email: _____ Phone: _____
Last, First ☐ *Home* ☐ *Cell* ☐ *Work*

Address: _____ Phone: _____
☐ *Home* ☐ *Cell* ☐ *Work*

City: _____ State: _____ County: _____ Zip Code: _____

Primary Care Provider/Pediatrician: _____ Phone: _____

Referral Source: _____

Newborn Hearing Screening: Results: ☐ Pass ☐ Refer ☐ Not Screened ☐ Refer with Risk Factors ☐ Pass with Risk Factors

Birth Hospital/Screening Hospital:

JCIH 2019 - Risk Factors for hearing loss: ☐ NA

Recommended Diagnostic Follow-up: Immediate referral

☐ Caregiver concern regarding hearing, speech, language, developmental delay and or developmental regression

Recommended Diagnostic Follow-up: No later than 3 months after occurrence

☐ Extracorporeal membrane oxygenation (ECMO)
☐ In utero infection with cytomegalovirus (CMV)
☐ Mother + Zika and infant with laboratory evidence of Zika + clinical findings
☐ Culture-positive infections associated with sensorineural hearing loss, including confirmed bacterial and viral (especially Herpes viruses and varicella) meningitis or encephalitis
☐ Events associated with hearing loss: *Significant head trauma especially basal skull/ temporal bone fractures; Chemotherapy*

Recommended Diagnostic Follow-up: By 9 months

☐ Family history of early, progressive, or delayed onset permanent childhood hearing loss
☐ NICU/PICU stay more than 5 days
☐ Hyperbilirubinemia with exchange transfusion regardless of length of stay
☐ Mother + Zika and infant with no laboratory evidence & no clinical findings
☐ Ototoxic medication exposure *Aminoglycoside/diuretic administration for more than 5 days, chemotherapeutic agents*
☐ In utero infections *Herpes, rubella, syphilis, and toxoplasmosis*
☐ Certain birth conditions or findings: *microtia/atresia, ear dysplasia, oral facial clefting, white forelock, and microphthalmia; Congenital microcephaly, congenital or acquired hydrocephalus; Temporal bone abnormalities*

Evaluation Procedures: ☐ Unable to Evaluate ☐ Refused Evaluation ☐ Did not show

Date: _____

☐ Initial Appointment
☐ Follow-up Appointment

☐ Air Conduction ABR
- ☐ Click
- ☐ Tone Bursts

☐ Bone Conduction ABR
- ☐ Click
- ☐ Tone Bursts

☐ Acoustic Immittance ***
- ☐ Tympanometry
- ☐ Acoustic Reflex
- ☐ Wideband

☐ Otoacoustic Emissions ***
☐ Visual Reinforcement Audiometry
☐ Auditory Steady-State Response ***

*** Cannot mark without ABR testing for confirmation of hearing status at initial appointment for children referring on newborn hearing screen.

Confirmed Hearing Status: *Indicate for each ear* ☐ Preliminary results: Additional testing required for confirmation of hearing loss

LEFT EAR		**RIGHT EAR**	
☐ Normal (-10 - 15 dB)	☐ Ear Malformation*	☐ Normal (-10 - 15 dB)	☐ Ear Malformation*
Degree of Hearing Loss	*Type of Hearing Loss*	*Degree of Hearing Loss*	*Type of Hearing Loss*
☐ Slight (16 - 25 dB)	☐ Nontransient Conductive	☐ Slight (16 - 25 dB)	☐ Nontransient Conductive
☐ Mild/Minimal (26 - 40 dB)	☐ Transient Conductive	☐ Mild/Minimal (26 - 40 dB)	☐ Transient Conductive
☐ Moderate (41 - 55 dB)	☐ Sensorineural	☐ Moderate (41 - 55 dB)	☐ Sensorineural
☐ Moderately Severe (56 - 70 dB)	☐ Mixed	☐ Moderately Severe (56 - 70 dB)	☐ Mixed
☐ Severe (71 - 90 dB)	☐ ANSD	☐ Severe (71 - 90 dB)	☐ ANSD
☐ Profound (>90 dB)		☐ Profound (>90 dB)	

Recommended Follow-up: ☐ within 1 month ☐ 3 months ☐ 6 months ☐ 12 months **Date:**

Referral:

☐ MS First Steps Early Intervention (*Any non-transient hearing loss, including unilateral loss, must be referred.*)
☐ Medical provider: _____ Appt. Date/Time: _____
☐ Second opinion: _____ Appt. Date/Time: _____
☐ Amplification Evaluation: _____ Appt. Date/Time: _____
☐ Amplification Fitting: _____ Appt. Date/Time: _____

Comments: *Please note any ear malformations (atresia, microtia, ear canal stenosis) or other relevant factors*

Name: _____ Facility: _____ Date: _____

MISSISSIPPI STATE DEPARTMENT OF HEALTH
FORM INSTRUCTIONS

HEARING DIAGNOSTIC REPORT

FORM NUMBER F-53
REVISION DATE 09/09/2024

RETENTION PERIOD
The MSDH-EHDI Program will retain this report for five (5) years. Other agencies, facilities, and medical providers will retain this report according to their applicable patient records retention policy.

PURPOSE

This form is intended to document and report the hearing diagnostic status of newborns/infants to the Mississippi State Department of Health.

INSTRUCTIONS

1. The *Hearing Diagnostic Report* form must be completed for all children ages birth to three years to enable appropriate follow-up and support in the following situations:
   a. The child was evaluated due to referral on a hearing screening.
   b. The child was present for the appointment but was not able to be evaluated for any reason (e.g., the evaluation device was broken or the child could not comply with the evaluation procedures).
   c. The family failed to return for a scheduled hearing appointment (i.e., no show).
   d. The family refused to have a hearing diagnostic evaluation conducted.
2. The *Hearing Diagnostic Report* form should be sent via encrypted email **within 48 hours** of an appointment or event necessitating a report (e.g., missed appointment or refusal).

   Email: EHDI@msdh.ms.gov

Please check the appropriate box and/or print the requested information in the space provided.

Demographic Data

- **Child Name:** Record the child's *current* last and first name.
- **Birth Name:** Record the child's last and first name *at birth*.
- **Date of Birth:** Record the month, day, and year the child was born.
- **Mother's Name:** Record the mother's current last and first name.
- **Email:** Record the mother's (or other parent/primary caregiver's) email address.
- **Phone:** Record the mother's (or other parent/primary caregiver's) area code and telephone number. Check the appropriate box to indicate the type of phone number recorded: Home, Cell, or Work.
- **Address:** Record the mother's (or other parent/primary caregiver's) mailing address.
- **Phone:** Record the mother's (or other parent/primary caregiver's) alternate area code and telephone number. Check the appropriate box to indicate the type of phone number recorded: Home, Cell, or Work.
- **City:** Record the mother's (or other parent/primary caregiver's) mailing address city.
- **State:** Record the mother's (or other parent/primary caregiver's) mailing address state.
- **County:** Record the mother's (or other parent/primary caregiver's) mailing address county.
- **Zip Code:** Record the mother's (or other parent/primary caregiver's) mailing address zip code.
- **Primary Care Provider/Pediatrician:** Record the name of the child's primary care provider or pediatrician.
- **Phone:** Record the primary care provider's or pediatrician's area code and telephone number.
- **Referral Source:** Record the name of the individual or facility (e.g., birthing hospital) that referred the child for an evaluation.

Newborn Hearing Screening

- **Results:** Check the appropriate box to indicate the hearing screening results:
  - **Pass:** Check the box if the child passed for both ears on the most recent hearing screening.
  - **Refer:** Check the box if the child referred for either or both ears on the most recent hearing screening.
  - **Not Screened:** Check the box if the child did not have a hearing screening conducted prior to a diagnostic evaluation.
  - **Refer with Risk Factors:** Check the box if the child referred on newborn hearing screen with risk factors.
  - **Pass with Risk Factors:** Check the box if the child passed newborn hearing screen, but has risk ractors.
- **Birth Hospital/Screening Hospital:** Record the name of the hospital where the child was born. If the child was not born in a hospital, enter the name of the facility or location of birth. If the child underwent screening at a hospital other than the one mentioned as birth hospital, please specify the screening hospital.

JCIH 2019 - Risk Factors for Late Onset Hearing Loss (Check *all* that apply. If none of these risk factors apply, check "NA" for *not applicable*.)

- **Caregiver concern:** Check the box if the child's parent or primary caregiver has expressed a concern about the child's hearing, speech, language, or development.
- **ECMO assisted ventilation:** Check the box if the child received extracorporeal membrane oxygenation (ECMO) assisted ventilation.
- **In-utero infection(s):** Check the box if the child was exposed to infections such as cytomegalovirus (CMV), herpes, rubella, syphilis, and toxoplasmosis in-utero.
- **Mother + Zika and infant with laboratory evidence of Zika + clinical findings:** Check the box if there is laboratory evidence of Zika + clinical findings.
- **Culture-positive infections associated with sensorineural hearing loss:** Check the box if the child has had a positive culture for a postnatal infection associated with sensorineural hearing loss, including confirmed bacterial and viral meningitis, especially herpes and varicella varieties.
- **Events associated with hearing loss:** Check the box if the child has had significant head trauma especially basal skull/temporal bone fractures; Chemotherapy.
- **Family history of early progressive, or delayed onset permanent childhood hearing loss:** Check the box if the child has a family member with a history of permanent childhood hearing loss.
- **NICU/PICU stay more than 5 days:** Check the box if the child spent more than five (5) calendar days in the NICU/PICU.
- **Hyperbilirubinemia with transfusion:** Check the box if the child received a transfusion as a result of hyperbilirubinemia.
- **Mother + Zika and infant with no laboratory evidence of Zika + no clinical findings:** Check the box if there is no laboratory evidence of Zika + no clinical findings.
- **Ototoxic medication exposure:** Check the box if the child was exposed to ototoxic medications (e.g., Aminoglycoside/diuretic administration for more than 5 days), chemotherapy drugs
- **In-utero infection(s):** Check the box if the child was exposed to infections such as cytomegalovirus (CMV), herpes, rubella, syphilis, and toxoplasmosis in-utero.
- **Certain birth conditions or findings:** Check the box if the child has any of the following: microtia/atresia, ear dysplasia, oral facial, clefting, white forelock, and, microphthalmia; Congenital microcephaly, congenital or acquired hydrocephalus; temporal bone abnormalities

Evaluation Procedures

Please print the appointment date in the space provided and check the appointment type.

- **Date:** Record the month, day, and year of the appointment.
- **Initial Appointment:** Check the box if the appointment is an initial diagnostic evaluation.
- **Follow-up Appointment:** Check the box if the appointment is a follow-up diagnostic evaluation.

If the evaluation was not completed, please check the appropriate box.

- **Unable to Evaluate:** Check the box if the child was present for the appointment but was not able to be evaluated for any reason (e.g., the evaluation device was broken or the child could not comply with the evaluation procedures).
- **Refused Evaluation:** Check the box if the family refused to have a hearing evaluation conducted.
- **Did not show:** Check the box if the family was not present for a scheduled hearing appointment. **Please check the appropriate boxes for the procedures conducted. Check *all* that apply.**
- **Air Conduction ABR:** Check the box if the evaluation includes an air conduction auditory brainstem response (ABR) procedure.
- **Bone Conduction ABR:** Check the box if the evaluation includes a bone conduction auditory brainstem response (ABR) procedure.
- **Click:** Check the box if the ABR procedure use clicks for stimuli.
- **Tone Bursts:** Check the box if the ABR procedure use tone bursts for stimuli.
- **Acoustic Immittance***:** Check the box if the evaluation includes measures of acoustic immittance. If so, indicate the method(s):
    - **Tympanometry:** Check the box if the evaluation includes tympanometry procedures.
    - **Acoustic Reflex:** Check the box if the evaluation includes acoustic reflex (thresholds/decay) testing.
    - **Wideband:** Check the box if the evaluation includes Wideband Acoustic Immittance (WAI) testing.
- **Otoacoustic Emissions***:** Check the box if the evaluation includes otoacoustic emission (OAE) procedures.
- **Visual Reinforcement Audiometry:** Check the box if the evaluation includes visual reinforcement audiometry (VRA) behavioral assessment procedures.
- **Auditory Steady-State Response***:** Check the box if the evaluation includes an auditory steady-state response (ASSR) procedure.

******Cannot mark without ABR testing for confirmation of hearing status at initial appointment for children referring on newborn hearing screen.***

Confirmed Hearing Status

If the results are not a confirmation of hearing loss, please check the appropriate box.

- **Preliminary results:** Check the box if the evaluation results are preliminary and additional testing will be required for confirmation of hearing loss.

To record results for the left and right ear, please check the appropriate box.

- **Normal:** Check the box if the child's hearing falls within normal limits using American Speech-Language-Hearing Association (ASHA) criteria.
- **Ear Malformation:** Check the box if the child has any form of ear malformation (e.g., atresia, microtia, or ear canal stenosis). Please provide additional details within the comment section.
- **Degree of Hearing Loss:** Check the appropriate box to indicate the degree of hearing loss for each ear using ASHA criteria: Slight, Mild/Minimal, Moderate, Moderately Severe, Severe, and Profound.
- **Type of Hearing Loss:** Check the appropriate box to indicate the type of hearing loss for each ear: Nontransient Conductive, Transient Conductive, Sensorineural, Mixed Conductive and Sensorineural, and Auditory Neuropathy Spectrum Disorder (ANSD).

Recommended Follow-up (if applicable)

- **Follow-up:** Check the appropriate box to indicate the timeframe for a scheduled subsequent diagnostic evaluation: Within 1 month, in 3 months, in 6 months, or in 12 months.
- **Date:** Record the month, day, and year of the scheduled follow-up appointment.

Referrals (if applicable)

- **MS First Steps Early Intervention:** Check the box to indicate if the child was referred to the Mississippi First Steps Early Intervention Program.

- **Medical provider:** Check the box if the child was referred to a primary or specialist medical provider for follow-up screening, evaluation, and/or treatment. Record the name of the medical provider and the month, day, year, and time of the scheduled appointment.
- **Second opinion:** Check the box if the child was referred to another audiologist for another diagnostic evaluation. Record the name of the audiologist and the month, day, year, and time of the scheduled appointment.
- **Amplification Evaluation:** Check the box if the child was referred for an evaluation for amplification devices. Record the name of the medical provider and the month, day, year, and time of the scheduled appointment.
- **Amplification Fitting:** Check the box if the child will return for fitting for amplification devices. Record the name of the medical provider and the month, day, year, and time of the scheduled appointment.

NOTE: Any child with <u>any</u> degree or type of hearing loss, including unilateral loss, <u>must</u> be referred for early intervention.

- **<u>Comments</u>** Record any additional information relevant for follow-up, including information about ear malformations, not included above.

<u>Reporting Source</u>

- **Name:** Record the name of the diagnostician completing the report.
- **Facility:** Record the name of the facility that conducted the hearing evaluation.
- **Date:** Record the month, day, and year the report was completed.

OFFICE MECHANICS AND FILING

After the *Hearing Diagnostic Report* form is completed, a copy should be sent via encrypted email to EHDI@msdh.ms.gov **<u>within 48 hours</u>**. In addition, a copy should be placed in the child's medical record. Copies should also be forwarded to the child's primary care provider and any outside referral (e.g., early intervention, medical provider, or audiologist).

The MSDH Early Hearing Detection and Intervention (EHDI) Program will enter this information into the EHDI database and place this report in the child's EHDI file.