Hearing Screening Report

Medical Record Number: _____ Birth Hospital: _____

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

Sex: _____ Race: _____ Ethnicity: _____ Gestational Age: _____weeks DOB: _____

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

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

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

Mother's DOB: _____ Race: _____ Ethnicity: _____ Language: _____ Education Level: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Provider/Pediatrician: _____ Insurance/Medicaid #: _____

Significant Medical History

Microtia	Atresia	Other:
☐ Left	☐ Left	
☐ Right	☐ Right	

Reason for Reporting:

- ☐ Referred on hearing screening
- ☐ Family refused hearing screening
- ☐ Did not show for a scheduled outpatient screening
- ☐ Has a risk factor(s) for late onset hearing loss
- ☐ No screening conducted – Reason: _____
- ☐ Deceased – Date of death: _____
- ☐ Transfer – Location: _____
- ☐ Other: _____

Risk Factors for Late Onset Hearing Loss: ☐ NA

- ☐ Caregiver concern
- ☐ Head trauma
- ☐ In-utero infection(s)
- ☐ Craniofacial anomalies
- ☐ Family history of hearing loss
- ☐ Neurodegenerative disorder
- ☐ Hyperbilirubinemia with transfusion
- ☐ ECMO assisted ventilation
- ☐ Physical findings/syndrome associated with hearing loss
- ☐ Postnatal infection associated with hearing loss
- ☐ Ototoxic medications/loop diuretic/chemotherapy
- ☐ NICU/PICU/PCICU > 5 days (*Number of days:* _____)

Hearing Screening Results: *Both ears must be screened simultaneously.*

FIRST SCREENING	SECOND SCREENING	*Optional*: THIRD SCREENING
Location: ☐ Inpatient ☐ Outpatient	Location: ☐ Inpatient ☐ Outpatient	Location: ☐ Inpatient ☐ Outpatient
Date: _____	Date: _____	Date: _____
Procedure: ☐ AABR ☐ OAE ☐ Other	Procedure: ☐ AABR ☐ OAE ☐ Other	Procedure: ☐ AABR ☐ OAE ☐ Other
Left Ear Results: ☐ Pass ☐ Refer ☐ DNT	Left Ear Results: ☐ Pass ☐ Refer ☐ DNT	Left Ear Results: ☐ Pass ☐ Refer ☐ DNT
Right Ear Results: ☐ Pass ☐ Refer ☐ DNT	Right Ear Results: ☐ Pass ☐ Refer ☐ DNT	Right Ear Results: ☐ Pass ☐ Refer ☐ DNT

Referral: ☐ Referred for Diagnostic Evaluation

- ☐ Hospital: _____ Appt. Date/Time: _____
- ☐ Audiologist: _____ Appt. Date/Time: _____
- ☐ Primary Care Provider: _____ Appt. Date/Time: _____

Comments:

Name: _____ Facility: _____ Date: _____

Fax/Mail to Mississippi State Department of Health or submit electronically via MS-HIN within 48 hours:

Mail: Early Hearing Detection and Intervention Program
570 East Woodrow Wilson, O-204
P.O. Box 1700, Jackson, Mississippi 39215-1700

Phone: 1-800-451-3903 / 601-576-7427

Fax: 601-576-7540

Form No. 288
Revised 12-15-2016

Hearing Screening Report – Form 288

Instructions

PURPOSE

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

INSTRUCTIONS

1. The *Hearing Screening Report* form must be completed to enable appropriate follow-up and support for the child and family for the following situations:
   a. The child referred on a second in-patient screening or third out-patient screening.
   b. The family refused to have a hearing screening conducted.
   c. The family failed to return for a scheduled third out-patient hearing appointment (i.e., no show).
   d. The child passed the hearing screening in both ears but has one or more risk factors for progressive or late onset hearing loss.
   e. The child did not receive a newborn hearing screening before discharge for any reason (e.g., the screening device was broken or the child has a medical condition or need for critical care that prevented a screening from being conducted).
   f. The child died before discharge and/or before a hearing screening could be conducted.
   g. The child was transferred to another hospital.
2. The *Hearing Screening Report* form should be mailed, faxed, or sent electronically through the Mississippi Health Information Network (MS-HIN) **within 48 hours** of an event necessitating a report (e.g., transfer, hearing screening, missed appointment, missed screening, or death).

   Fax: (601) 576-7540
   Mail: Mississippi State Department of Health (MSDH)
   Early Hearing Detection and Intervention (EHDI)
   P.O. Box 1700
   Jackson, MS 39215-1700
   MS-HIN: msdh-ehdi@ms-hin.medicity.net

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

Demographic Data

- **Medical Record Number:** Record the child's permanent medical record number assigned by the medical facility.
- **Birth 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.
- **Child Name:** Record the child's *current* last and first name.
- **Birth Name:** Record the child's last and first name *at birth*.
- **Sex:** Record the child's sex using one of the following options:
  (M) Male (F) Female (U) Unknown
- **Race:** Record the child's race as defined by the child's parent using one of the following options:
  (W) White (AS) Asian (B/AA) Black or African American
  (OTH) Other (U) Unknown (AI/AN) American Indian & Alaskan Natives
  (PI) Native Hawaiians & Other Pacific Islanders
- **Ethnicity:** Record child's ethnicity as defined by the child's parent using one of the following options:
  (H) Hispanic (NH) Not Hispanic (U) Unknown
- **Gestational Age:** Record the child's gestational age in weeks.
- **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.
- **Mother's DOB:** Record the mother's month, day, and year of birth, if known, or (U) Unknown.
- **Mother's Race:** Record the mother's race using one of the following options:
  (W) White (AS) Asian (B/AA) Black or African American
  (OTH) Other (U) Unknown (AI/AN) American Indian & Alaskan Natives
  (PI) Native Hawaiians & Other Pacific Islanders
- **Mother's Ethnicity:** Enter mother's ethnicity using one of the following options:
  (H) Hispanic (NH) Not Hispanic (U) Unknown
- **Mother's Language:** Record the mother's (or other parent/primary caregiver's) primary language.
- **Mother's Education Level:** Record the mother's educational level using one of the following options:
  (LS) Less than high school (SC) some college or AA/AS degree
  (HS) High school graduate/GED (CG) College graduate or above
  (U) Unknown
- **Emergency Contact's Name:** Record the name of an emergency contact for the child.
- **Emergency Contact's Phone:** Record the emergency contact's phone number.
- **Primary Care Provider/Pediatrician:** Record the name of the child's primary care provider or pediatrician.
- **Insurance/Medicaid #:** Record the individual or group insurance number for the child.

Significant Medical History

- **Microtia:** Check the appropriate box for the left or right ear, if applicable.
- **Atresia:** Check the appropriate box for the left or right ear, if applicable.
- **Other:** Record a description of any relevant medical history, noting conditions requiring follow-up.

Reason for Reporting (Check *one* of the following to indicate the reason for the report.)

- **Referred on hearing screening:** Check the box if the child referred on the left, right, or both ears on a second in-patient screening (if this was the final screening) or third out-patient screening (if provided).
- **Family refused hearing screening:** Check the box if the family refused to have a hearing screening conducted.
- **Did not show for a scheduled outpatient screening:** Check the box if the family failed to return for a third out-patient hearing appointment (i.e., no show).
- **Has a risk factor(s) for late onset hearing loss:** Check the box if one or more risk factors for late onset hearing loss have been reported. Indicate the risk factor(s) in the following section.
- **No screening conducted – Reason:** Check the box if a hearing screening was not conducted. Record the reason the hearing screening was not conducted (e.g., the screening device was broken or the child's medical condition prevented a hearing screening from being conducted).

- **Deceased – Date of Death:** Check the box if the child died before discharge. Record the month, day, and year of the child's date of death.
- **Transfer – Location:** Check the box if the child was transferred to another facility. Record the name of the facility to which the child was transferred.
- **Other:** Check the box if the Hearing Screening Report is submitted for any reason not listed. Record the reason.

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.
- **Family History of Hearing Loss:** Check the box if the child has a family member with a history of permanent childhood hearing loss.
- **Physical findings/Syndrome associated with Hearing Loss:** Check the box if the child has a syndrome associated with hearing loss or progressive/late onset hearing loss (e.g., neurofibromatosis, osteopetrosis, or Usher, Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson syndromes) or physical characteristics associated with sensorineural or permanent conductive hearing loss (e.g., white forelock).
- **Head Trauma:** Check the box if the child received any head trauma, especially a basal skull/temporal bone fracture requiring hospitalization.
- **Neurodegenerative disorder:** Check the box if the child has a neurodegenerative disorders (e.g., Hunter syndrome) or sensory motor neuropathies (e.g., Friedreich's ataxia and Charcot-Marie-Tooth syndrome).
- **Postnatal infection associated with 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.
- **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.
- **Hyperbilirubinemia with transfusion:** Check the box if the child received a transfusion as a result of hyperbilirubinemia.
- **Ototoxic medications/loop diuretic/chemotherapy:** Check the box if the child was exposed to ototoxic medications (e.g., gentamicin and tobramycin), loop diuretics (e.g., furosemide/lasix), or chemotherapy drugs.
- **Craniofacial anomalies:** Check the box if the child has any craniofacial anomalies, including pinna, ear canal, ear tags, ear pits, and temporal bone anomalies.
- **ECMO assisted ventilation:** Check the box if the child received extracorporeal membrane oxygenation (ECMO) assisted ventilation.
- **NICU/PICU/PCICU > 5 Days (Number of days: _____):** Check the box if the child spent more than five (5) calendar days in the NICU/PICU/PCICU. Record the total number of days the infant was hospitalized in the NICU/PICU/PCICU.

Record the results for the first, second, and (optional) third screening, if conducted.
NOTE: Both ears must be screened simultaneously for each hearing screening conducted.

Hearing Screening Results

- **Location:** Check the appropriate box to indicate the location where the hearing screening was conducted: Inpatient or Outpatient.
- **Date:** Record the month, day, and year the hearing screening was conducted.
- **Procedure:** Check the appropriate box to indicate the type of hearing screening conducted: AABR (automated auditory brainstem responses), OAE (otoacoustic emissions), or Other.

- **Left Ear Result /Right Ear Results:** Check the appropriate box to indicate the results of the hearing screening conducted for each ear: Pass, Refer, or DNT (Did Not Test).

Referrals

- **Referred for Diagnostic Evaluation:** Check the box to indicate if the child was referred for a diagnostic evaluation.
- **Hospital:** Check the box if the child was referred to a hospital for follow-up screening, evaluation, and/or treatment. Record the name of the hospital and the month, day, year, and time of the scheduled appointment.
- **Audiologist:** Check the box if the child was referred to an audiologist for diagnostic evaluation. Record the name of the audiologist or clinic and the month, day, year, and time of the scheduled appointment.
- **Primary Care Provider:** Check the box if the child was referred to a primary care provider. Record the name of the primary care provider name and the month, day, year, and time of the schedule appointment.

NOTE: Any child who refers in the left, right, or both ears on a second inpatient (if this is the final screening) or third outpatient (if provided) hearing screening must be referred for a diagnostic evaluation.

Comments Record any additional information relevant for follow-up, including information about the parent/primary caregiver (e.g., the family is moving or the child has been placed with a foster family) or the child.

Reporting Source

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

OFFICE MECHANICS AND FILING

After the *Hearing Screening Report* form is completed, a copy should be mailed, faxed, or sent electronically through the Mississippi Health Information Network (MS-HIN) **within 48 hours** to the Mississippi State Department of Health (MSDH). 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 the child's 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.

RETENTION PERIOD

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