Table 1
Risk Factors for Early Childhood Hearing Loss: Guidelines for Infants who Pass the Newborn Hearing Screen

	Risk Factor Classification	Recommended Diagnostic Follow-up	Monitoring Frequency
	Perinatal		
1	Family history* of early, progressive, or delayed onset permanent childhood hearing loss	by 9 months	Based on etiology of family hearing loss and caregiver concern
2	Neonatal intensive care of more than 5 days	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
3	Hyperbilirubinemia with exchange transfusion regardless of length of stay	by 9 months	
4	Aminoglycoside administration for more than 5 days**	by 9 months	
5	Asphyxia or Hypoxic Ischemic Encephalopathy	by 9 months	
6	Extracorporeal membrane oxygenation (ECMO)*	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
7	In utero infections, such as herpes, rubella, syphilis, and toxoplasmosis	by 9 months	As per concerns of on-going surveillance
	In utero infection with cytomegalovirus (CMV)*	No later than 3 months after occurrence	Every 12 months to age 3 or at shorter intervals based on parent/provider concerns
	Mother + Zika and infant with no laboratory evidence & no clinical findings	standard	As per AAP (2017) Periodicity schedule
	Mother + Zika and infant with laboratory evidence of Zika + clinical findings Mother + Zika and infant with laboratory evidence of Zika - clinical findings	AABR by 1 month AABR by 1 month	ABR by 4-6 months or VRA by 9 months ABR by 4-6 months Monitor as per AAP (2017) Periodicity schedule (Adebanjo et al., 2017)
8	Certain birth conditions or findings: • Craniofacial malformations including microtia/atresia, ear dysplasia, oral facial clefting, white forelock, and microphthalmia • Congenital microcephaly, congenital or acquired hydrocephalus • Temporal bone abnormalities	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
9	Over 400 syndromes have been identified with atypical hearing thresholds***. For more information, visit the Hereditary Hearing Loss website (Van Camp & Smith, 2016)	by 9 months	According to natural history of syndrome or concerns
	Perinatal or Postnatal		
10	Culture-positive infections associated with sensorineural hearing loss***, including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis or encephalitis	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
11	Events associated with hearing loss: • Significant head trauma especially basal skull/temporal bone fractures • Chemotherapy	No later than 3 months after occurrence	According to findings and or continued concerns
12	Caregiver concern**** regarding hearing, speech, language, developmental delay and or developmental regression	Immediate referral	According to findings and or continued concerns

Note. AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response.
* Infants at increased risk of delayed onset or progressive hearing loss
**Infants with toxic levels or with a known genetic susceptibility remain at risk
***Syndromes (Van Camp & Smith, 2016)
****Parental/caregiver concern should always prompt further evaluation.

overall health of the patient (Lowe & Vézina, 2005). Malformations of the external, middle, and inner ear as well as the internal auditory canal are clearly detectable using currently available imaging. Structural anomalies of the cochleovestibular nerves and brain are also discernable in most cases. In general, high resolution computed tomography (HRCT) is well-suited for assessing the osseous structures (external auditory canal and middle ear), while magnetic resonance imaging (MRI) provides excellent soft tissue and fluid detail for looking at the cranial nerves and brain (Lowe & Vézina, 2005). The inner ear including the vestibular aqueduct (endolymphatic duct) is well visualized using either MRI or HRCT.