**EARLY HEARING DETECTION AND INTERVENTION**
**Nebraska Newborn Hearing Screening Program**
**Audiologic Screening and Diagnostic Report Form**

Infant's Name:_____Date of Birth: (____/____/____)

Mother's Name:_____

Primary Care Provider:_____

Birth Hospital: _____

**Screening/Evaluation Information**: Audiology Facility:_____Date:(_____/_____/_____)

**Audiologist:**_____

**OAE Screening Results**:

Left Ear ☐ Pass ☐ Refer ☐ Not Tested

Right Ear: ☐ Pass ☐ Refer ☐ Not Tested

**Tympanometry Results:**

Left Ear ☐ Normal ☐ Abnormal ☐ Not Tested

Right Ear: ☐ Normal ☐ Abnormal ☐ Not Tested

Circle one: **ABR | ABR Screening | Behavioral (VRA, CPA)** (If filling out form digitally, choose from the drop down box) ABR Screening

| ***Left Ear*** | | ***Right Ear*** | |
|---|---|---|---|
| ☐ Normal Hearing<br>☐ Mild (21-40 dB HL)<br>☐ Moderate (41-70 dBHL) | ☐ Conductive<br>☐ Sensorineural<br>☐ Mixed<br>☐ Undetermined | ☐ Normal Hearing<br>☐ Mild (21-40 dB HL)<br>☐ Moderate (41-70 dBHL) | ☐ Conductive<br>☐ Sensorineural<br>☐ Mixed<br>☐ Undetermined |
| ☐ Severe (71-90 dB HL)<br>☐ Profound (91+ dB HL)<br>☐ Auditory Neuropathy | ☐ Permanent<br>☐ Transient<br>☐ Fluctuating<br>☐ Undetermined | ☐ Severe (71-90 dB HL)<br>☐ Profound (91+ dB HL)<br>☐ Auditory Neuropathy | ☐ Permanent<br>☐ Transient<br>☐ Fluctuating<br>☐ Undetermined |

Notes:_____

_____

**Disposition:**

Screening/Evaluation results provided to infant's Primary Care Provider: ☐ Yes ☐ No

☐ Additional Screening/Evaluation: Audiology Facility: _____Date: (_____/_____/_____)

Hearing Aid(s) ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

Cochlear Implant(s) ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

FM System ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

ENT Evaluation ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

Genetic Evaluation ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

Ophthalmology Evaluation ☐Recommended (_____/_____/_____) ☐Received (_____/_____/_____)

Early Development Network ☐Recommended (_____/_____/_____) ☐Receiving (_____/_____/_____)

Discussed communication options: ☐ Yes ☐ No

Other: _____

*Mail or fax to:*

Nebraska Newborn Hearing Screening Program
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Phone 888-545-0935
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