Ohio Department of Health – Infant Hearing Program

Universal Newborn Hearing Screening Report

email to: infanthearingprogram@odh.ohio.gov

Hospital Name _____ Label (optional)

BIRTH

☐ Home birth ☐ Re-admit ☐ NICU admission ☐ Out-of-state birth admit

☐ Single ☐ Multiple: If multiple order delivered:_____			Infant's birthdate (mm/dd/yyyy)
Infant's Name Last	First	Middle Initial	Suffix
Mother's Name Last	First	Middle Initial	Maiden
Mother's Address - Number & Street		Apartment	County of residence
City	State	Zip	Country, if not US
Primary phone number	Cell phone number		☐ No Phone

DISCHARGE CAREGIVER, IF NOT MOTHER

Name	Relationship
Address	Phone number

PRIMARY CARE PROVIDER (Physician/Nurse practitioner who will care for infant after hospital discharge)

Provider name			
Practice name			Office Number
Practice address	City	State	Zip

TRANSFER INFORMATION (Indicate location and date transferred if not reporting in OVRS.)

☐ Reverse Transfer

To:	Date: (mm/dd/yyyy)	State (if not Ohio):
From:	Date: (mm/dd/yyyy)	State (if not Ohio):

HEARING SCREENING NO. 1 COMPLETED? (Fill out section completely)

☐ Yes ☐ No

If not, why select 1 reason?

☐ Objected ☐ Transferred ☐ Deceased (*date*)_____ (mm/dd/yyyy)

☐ Equipment malfunction

☐ Discharge without screen

SCREENING NO. 1 RESULTS

Date (mm/dd/yyyy)

Screener name *last* *first*

Method ☐ OAE ☐ ABR

Right ear ☐ Pass ☐ Non-pass ☐ Physical Condition

Left ear ☐ Pass ☐ Non-pass ☐ Physical Condition

HEARING SCREENING NO. 2 COMPLETED? (Fill out section completely)

☐ Yes ☐ No

If not, why select 1 reason?

☐ Objected ☐ Transferred ☐ Deceased (*date*)_____ (mm/dd/yyyy)

☐ Equipment malfunction

☐ Discharge without screen

SCREENING NO. 2 RESULTS

Date (mm/dd/yyyy)

Screener name *last* *first*

Method ☐ OAE ☐ ABR

Right ear ☐ Pass ☐ Non-pass ☐ Physical Condition

Left ear ☐ Pass ☐ Non-pass ☐ Physical Condition

RISK FACTORS (Check all that apply)

☐ Family history of permanent childhood hearing loss ☐ Craniofacial anomalies ☐ Neonatal Intensive Care Unit >5 days

☐ Hyperbilirubinemia with Exchange Transfusion ☐ Aminoglycoside Adminstration >5 days ☐ Asphyxia or Hypoxic Ischemic Encephalopathy

☐ ECMO ☐ In utero infections ☐ CMV ☐ Cranio-facial Anomalies ☐ Caregiver Concern ☐ Unknown

☐ Congenital microcephaly, congenital of acquired hydrocephalus ☐ Temporal Bone Abnormalities ☐ Perinatal Syndrome ☐ Postnatal Syndrome

☐ Culture-Positive Postnatal infections ☐ Significant Head Trauma ☐ Chemotherapy

☐ Other:_____ ☐ None of the above

Instructions for Universal Newborn Hearing Screening Report

Under Ohio law, hospitals are required to report the hearing screening results of newborns and infants to the Ohio Department of Health within **10 calendar days from when the hearing screenings were conducted (in accordance with ohio-revised-code/section-3701.503-509).**

Upon completion of this form you can either:

- **fax:** 614-728-9163
- **email:** infanthearingprogram@odh.ohio.gov

For assistance, contact the Infant Hearing Program at 614-387-0135.

Hospital name — Enter official hospital name, not abbreviated name or initials.

Label space. (Optional)

Birth — Check off home birth, re-admit, NICU admission, or out of state birth admit. If multiple, indicate order delivered: first, second, third, fourth, etc.

Infant birth date — mm/dd/yyyy.

Infant's legal name — Last, first, middle names, and suffix.

Mother's legal name — Last and first names.

Mother's address — Mailing address includes, Street, City, County, Zip and 2-digit state abbreviation.

Telephone — Ten-digit phone number including area code for primary and alternative phones where someone can contact the parent.

Discharge caregiver if NOT mother — If the baby is going home with the mother, check "**Not Applicable.**"List the caregiver's last and first names, address, and contact phone number. Enter the relationship information.

Infant's primary care provider (important for follow up) — Provider name, practice name, address, and phone number.

Newborn transferred —

To — List facility infant transferred to.
From — List facility infant transferred from.
Date — Date infant transferred.
State — If not Ohio.

Hearing screening No.1 completed? — Select one reason.

Hearing screening No.1 results — (all fields required if answered Yes above).

Date — Date screening conducted in mm/dd/yyyy format.
Screener name — First and last names are required.
Method — Check method: OAE or ABR.
Left ear — Check either Pass, Non-pass, or Physical condition.
Right ear — Check either Pass, Non-pass, or Physical Condition.

Hearing screening No.2 completed? Select one reason.

Hearing screening No.2 results — (all fields required if answered Yes above).

Date — Date screening conducted in mm/dd/yyyy format.
Screener name — First and last names are required.
Method — Check method: OAE or ABR.
Left ear — Check either Pass, Non-pass, or Physical Condition.
Right ear — Check either Pass, Non-pass, or Physical Condition.

Risk factors and transfers

Risk factors — Check all risk factors that apply.