Ohio Department of Health – Infant Hearing Program

Universal Newborn Hearing Screening Report

Hospital name

Infant's Medical Record Number

Addressograph or label (optional)

Birth See instructions on back ☐ Home birth ☐ Re-admit ☐ Out of state birth admit

☐ Single ☐ Multiple: Code # ____________ Order delivered: ________________

Infant's birthdate *(mm/dd/yyyy)*

Infant's name *last* *first* *middle* *suffix*

Preferred parentage title *(check one)*	Gender *(check one)*	Preferred parentage title *(if applicable)*	Gender *(check one)*
☐ Mother ☐ Father ☐ Parent	☐ Female ☐ Male	☐ Mother ☐ Father ☐ Parent	☐ Female ☐ Male

Birth parent current legal name *last* *first*

Second birth parent current legal name *last* *first*

Parent's address *(number and street)* | Apartment | County of residence

City | State | Zip | Country, if not US

Primary phone number | Cell phone number | ☐ No phone

Discharge caregiver, if NOT birth parent *(If baby is not going home with birth parent add code # and complete below)*

☐ Not Applicable ☐ Code#: ___________

Name *last* *first* | Relationship

Address | Phone number

Primary Care Provider *(Physician/Nurse practitioner who will care for infant after hospital discharge)*

Provider name

Practice name | Office phone number

Practice address | City | State | Zip

Hearing screening #1 completed? *(Fill out section completely)*

☐ Yes ☐ No

If not, why? *(mm/dd/yyyy)*

☐ Objected ☐ Transferred ☐ Deceased *(date)* ____________

☐ Equipment malfunction ☐ Early discharge

☐ Missed ☐ Physical anomaly

Screening #1 results

Date *(mm/dd/yyyy)*

Screener name *last* *first*

Method ☐ OAE ☐ ABR

Right ear ☐ Pass ☐ Non-pass | Left ear ☐ Pass ☐ Non-pass

Hearing Screening # 2 Completed? *(Fill out section completely)*

☐ Yes ☐ No

If not, why? *(mm/dd/yyyy)*

☐ Objected ☐ Transferred ☐ Deceased *(date)* ____________

☐ Equipment malfunction ☐ Early discharge

☐ Missed ☐ Physical anomaly

Screening #2 results

Date *(mm/dd/yyyy)*

Screener name *last* *first*

Method ☐ OAE ☐ ABR

Right ear ☐ Pass ☐ Non-pass | Left ear ☐ Pass ☐ Non-pass

Risk Factors *(Check all that apply)*

☐ Not known ☐ None ☐ Family history of childhood hearing loss

☐ Illness or condition requiring 5 days or greater in NICU ☐ Ototoxic medications ☐ Craniofacial anomalies

☐ Syndrome/stigmata associated with hearing loss ☐ In utero infection (TORCHS) ☐ Other:______________________________

Transfer Information *(Indicate location and date transferred)* ☐ Reverse Transfer

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

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

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Submit forms via infanthearingprogram@odh.ohio.gov or by FAX 614-728-9163

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 rule 3701-40-08 of the Administrative Code).**

Upon completion of this form you can either:

- **fax:** 614-728-9163
- **email:** infanthearingprogram@odh.ohio.gov
- **click on:** "submit button" on page 1 of this form
- **mail to:** Infant Hearing Program, Ohio Department of Health, 246 North High Street, 5th Floor Columbus, OH 43215

For Assistance contact the Infant Hearing Program at 614-387-0135

I. Hospital Information

1. **Hospital name** — Enter official hospital name, not abbreviated name or initials
2. **Infant's medical record number**— Obtain this number from the chart
3. **Addressograph or label space** (optional)

II. Patient demographics/PCP information

1. **Birth** — Check off Home Birth, Re-admit or Out of state if applicable. Check single or enter correct code for multiple:
   2 (twin)
   3 (triplet)
   4 (quadruplet), etc.

   If multiple, indicate order delivered: 1st, 2nd, 3rd, 4th, etc.
2. **Infant birth date** — MM/DD/YYYY
3. **Infant's name** — Last, first, middle names and suffix
4. **Birth parent current legal name** — Last and first names
   NOTE: Check parentage title and gender
5. **Second birth parent current legal name if applicable** — Last and first names
   NOTE: Check parentage title and gender
6. **Parent's address if applicable** — Mailing address includes, Street, City, County, Zip and 2-digit state abbreviation
7. **Telephone** — Ten-digit phone number including area code for primary and alternative phones where someone can contact the parent
8. **Discharge caregiver if NOT birth parent** — If the baby is going home with the birth parent, check **"Not Applicable."** If someone else will be the caregiver, list the correct code number:
   1 (legal guardian)
   2 (adoption agency)
   3 (other = state relationship) in box provided

   List the caregiver's last and first names, address and contact phone number. Enter the relationship information
9. **Infant's primary care provider (important for follow up)**
   Primary care provider — Provider name, practice name, address and phone number

III. Hearing screening

1. **Hearing screening #1 completed?** — Check Yes or No If screening was **NOT** completed, indicate reason; check one of the boxes: objected, transferred, deceased, etc.
2. **Hearing screening #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
   Right ear — Check either Pass or Non-pass
   Left ear — Check either Pass or Non-pass
3. **Hearing screening #2 completed?** Check Yes or No.
   If screening was **NOT** completed, indicate reason; check one of the boxes: objected, transferred, deceased, etc.
4. **Hearing screening # 2 results— Both ears need to be screened** if Non-pass selected in Screening #1 for either ear (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
   Right ear — Check either Pass or Non-pass
   Left ear — Check either Pass or Non-pass

IV. Risk factors and transfers

1. **Risk factors** —
   Check all risk factors that apply
   If no information is known regarding risk factors, check the **'Not known'** box

   If the infant has risk factors other than those listed on this form, check "**Other,"** and enter risk factors
2. **Newborn transferred** —
   To — List facility infant transferred to
   From — List facility infant transferred from
   Date — Date infant transferred
   State — If not Ohio