



Iowa's Early Hearing Detection and Intervention Screening Re-screening Reporting

Results must be reported within 6 days of the hearing screen/re-screen being performed within the EHDI database.

Screening Site:	Screening Date:
Patient Name (Last, First, MI):	Medical Record Number:
Patient Demographics:	

Date of Birth: Gestational Age (weeks): Gender:
 Hospital/Place of Birth: Race:
 Nursery: Time of Birth: Ethnicity:
 Birth Weight (grams):
 Primary Care Provider:

Mother / Guardian Information:	
Name (Last, First, MI):	Home Phone:
Address:	Cell Phone:
Language:	Email:

Risk Factors:		
<input type="checkbox"/> None	<input type="checkbox"/> NICU > 5 Days	<input type="checkbox"/> ECMO
<input type="checkbox"/> Congenital infection (herpes, syphilis)	<input type="checkbox"/> Craniofacial anomalies	<input type="checkbox"/> Head injury
<input type="checkbox"/> Family history of childhood hearing loss	<input type="checkbox"/> Asphyxia or HIE	<input type="checkbox"/> Exchange transfusion for elevated bilirubin
<input type="checkbox"/> Congenital Cytomegalovirus (CMV)	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Aminoglycosides for > 5 days
<input type="checkbox"/> Syndrome	<input type="checkbox"/> Chemotherapy	

Results:			
Screening date:	Technology used:	Result for Left Ear:	Result for Right Ear:
mo day yr	DPOAE	Pass	Pass
	TEOAE	Did Not Pass	Did Not Pass
Screening Type:	AABR	Not screened	Not screened
Birth Admit		list reason:	list reason:
Outpatient			

Diagnostic Assessment Location:
 Diagnostic Assessment Appointment Date:

Comments:

Screen Performed By:

Today's Date: