

Audiological Diagnostic/Follow-up Report

Birth/New Last Name: _____ First _____ DOB: _____
 Mother's Name: _____
 Home Address: _____ Phone #: _____
 City: _____ State _____ County _____ Zip Code: _____
 Primary Care Provider and/or Pediatrician: _____ Phone #: _____
 Referral Source: _____
 Medicaid # _____ Insurance # and Company Name _____

| | |
|---|--|
| <p>Is this baby at risk for hearing loss? YES NO</p> <p> <input type="checkbox"/> Perinatal or caregiver concern <input type="checkbox"/> Family History <input type="checkbox"/> Postnatal Infection <input type="checkbox"/> Syndrome <input type="checkbox"/> Congenital perinatal infections <input type="checkbox"/> Head trauma <input type="checkbox"/> Hyperbilirubinemia TX _____ <input type="checkbox"/> Neurodegenerative disorder: _____ <input type="checkbox"/> Recurrent or persistent OM _____ <input type="checkbox"/> NICU > 48 hours: Reason: _____ </p> | <p>Date of Exam</p> <p>[] Initial Appointment</p> <p>[] Follow-up Appointment</p> <p>[] Patient did not show</p> <p>Next scheduled appointment date _____</p> |
|---|--|

Testing conducted by: ABR _____ OAE _____ Behavior _____ Tymp _____ Probe Freq. _____

RESULTS: Passed both ears _____ Did not pass right ear _____ Did not pass left ear _____

HEARING LOSS: (Please circle for each ear)

| | (21 - 40 dB HL) | (41-70dB HL) | (71-90dB HL) | (91+dB HL) |
|------------|-----------------|--------------|--------------------------|------------|
| Right ear: | Mild | Moderate | Severe | Profound |
| | Sensorineural | Mixed | Non-Transient Conductive | R/O OM |
| Left ear: | Mild | Moderate | Severe | Profound |
| | Sensorineural | Mixed | Non-Transient Conductive | R/O OM |

Confirmed Loss Auditory Neuropathy Refused Diagnostic

PLAN OF CARE:

Referral for Medical Evaluation-Physician _____ Date _____

Hearing Aid Evaluation-Facility _____ Date _____

Recommended Follow-up Schedule - (circle) 3 months 6 months annual other _____

[] Refer to Early Intervention Program [] Refer for 2nd opinion Facility _____

Audiologist _____ Facility _____ Phone # _____

Comments: _____

Fax: 601-576-7540
 Phone: 1-800-451-3903
 or 601-576-7427

Forward to: Mississippi State Department of Health
 570 East Woodrow Wilson Blvd
 Jackson, Mississippi 39215

Fax or mail within 48 hours

