DEPARTMENT OF HEALTH

NEWBORN HEARING SCREENING OUTPATIENT FOLLOW-UP REPORT FORM

OUTPATIENT SCREENING • APPOINTMENT CHANGE • REFERRALS

PATIENT INFORMATION

Child's Name (Last, First): Date of Birth: Gender Assigned at Birth: Female Male

Address, City, State:

Mother/Parent's Name (Last, First): Phone:

Caregiver's Name/Relationship/Phone (if different): Language Used in Home:

Primary Care Physician: Primary Clinic Name, City:

If not MN birth, **include birth hospital or home birth city/state**:

APPOINTMENT CHANGE

Date of Appointment: Cancelled Did Not Show New Appointment Date:

TEST RESULTS

IMPORTANT: DO NOT DELAY COMPLETE AUDIOLOGICAL DIAGNOSIS DUE TO MIDDLE EAR FLUID

Date of Service: First Outpatient Visit? Yes No

Audiologist: Clinic Name, City:

SCREENING RESULTS ✓ ALL THAT APPLY	RIGHT EAR			LEFT EAR		
AABR (screening)	Pass	Refer	Not Done	Pass	Refer	Not Done
DPOAE	Pass	Refer	Not Done	Pass	Refer	Not Done
TEOAE	Pass	Refer	Not Done	Pass	Refer	Not Done
Tympanometry	Peak		No Peak	Peak		No Peak
226 Hz 1000 Hz	Rounded		Large Volume	Rounded		Large Volume

**If result is REFER for one or both ears, schedule a diagnostic audiology appointment as soon as possible*

REFERRALS AND APPOINTMENTS ✓ CHECK ALL THAT APPLY IF KNOWN

Audiology	Clinic Referred To:	Appointment Date:
Otolaryngology	Clinic Referred To:	Appointment Date:

NOTES

FAX COMPLETED FORM TO NEWBORN SCREENING (651) 215-6285

For more information, please contact health.newbornhearing@state.mn.us

REV: 3/2022