DEPARTMENT OF HEALTH

Hearing Screening and Pulse Oximetry (CCHD) Result Report Form

Infant's Name:

Infant's DOB:

Birthing Parent's Name:

Screening Provider/Location:

Primary Care Physician (name/location):

Hearing Screening Results

Date of Screening:

Screening Provider/Location:

Right Ear: ☐ Pass ☐ Refer

Left Ear: ☐ Pass ☐ Refer

Hearing Rescreening Results

Date of Rescreening:

Screening Provider/Location:

Right Ear: ☐ Pass ☐ Refer

Left Ear: ☐ Pass ☐ Refer

If one or both ears do not pass the hearing rescreen, please indicate scheduled diagnostic appointment information (date and location) in the comments section.

Pulse Oximetry (CCHD) Screening Results

Date of Screening:

Screening Provider/Location:

1st Screen Result:	2nd Screen Result:	3rd Screen Result:
Time of Screen:	Time of Screen:	Time of Screen:
Hand (Sat Value):	Hand (Sat Value):	Hand (Sat Value):
Foot (Sat Value):	Foot (Sat Value):	Foot (Sat Value):
Heart Rate:	Heart Rate:	Heart Rate:

*The Minnesota Department of Health does not require the baby's heart rate.

Additional Comments:

FAX, email, or mail this result report to the Minnesota Department of Health within 48 hours of screening.

Send or fax completed form to:
Minnesota Department of Health
Newborn Screening Program
P.O. Box 64899
St.Paul, MN 55164-0899

Phone: (800) 664-7772
Fax: (651) 215-6285
Email: newbornscreening@health.state.mn.us
Website: www.health.state.mn.us/newbornscreening
REV Date: 3/2024