

# Ohio Department of Health – Infant Hearing Program

## Universal Newborn Hearing Screening Report

Hospital name
Infant's Medical Record Number

Addressograph or label (optional)

<b>Birth</b> See instructions on back <input type="checkbox"/> Home birth <input type="checkbox"/> Re-admit <input type="checkbox"/> Out of state birth admit			
<input type="checkbox"/> Single <input type="checkbox"/> Multiple:    Code # _____    Order delivered: _____		Infant's birthdate (mm/dd/yyyy)	
Infant's name    last    first    middle    suffix			
Preferred parentage title (check one) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent		Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	
Preferred parentage title (if applicable) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent		Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male	
Birth parent current legal name    last    first		Second birth parent current legal name    last    first	
Parent's address (number and street)			Apartment
City			State
Zip		Country, if not US	
Primary phone number		Cell phone number <input type="checkbox"/> No phone	
Discharge caregiver, if NOT birth parent (If baby is not going home with birth parent add code # and complete below)			
<input type="checkbox"/> Not Applicable <input type="checkbox"/> Code#: _____			
Name    last    first		Relationship	
Address		Phone number	
<b>Primary Care Provider</b> (Physician/Nurse practitioner who will care for infant after hospital discharge)			
Provider name			
Practice name			Office phone number
Practice address		City	State
Zip		Zip	
<b>Hearing screening #1 completed?</b> (Fill out section completely)		<b>Screening #1 results</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Date (mm/dd/yyyy)	
If not, why?    (mm/dd/yyyy)		Screener name    last    first	
<input type="checkbox"/> Objected <input type="checkbox"/> Transferred <input type="checkbox"/> Deceased (date) _____		Method <input type="checkbox"/> OAE <input type="checkbox"/> ABR	
<input type="checkbox"/> Equipment malfunction <input type="checkbox"/> Early discharge		Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass    Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass	
<input type="checkbox"/> Missed <input type="checkbox"/> Physical anomaly		Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass	
<b>Hearing Screening # 2 Completed?</b> (Fill out section completely)		<b>Screening #2 results</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Date (mm/dd/yyyy)	
If not, why?    (mm/dd/yyyy)		Screener name    last    first	
<input type="checkbox"/> Objected <input type="checkbox"/> Transferred <input type="checkbox"/> Deceased (date) _____		Method <input type="checkbox"/> OAE <input type="checkbox"/> ABR	
<input type="checkbox"/> Equipment malfunction <input type="checkbox"/> Early discharge		Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass    Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass	
<input type="checkbox"/> Missed <input type="checkbox"/> Physical anomaly		Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Non-pass	
<b>Risk Factors</b> (Check all that apply)			
<input type="checkbox"/> Not known <input type="checkbox"/> None <input type="checkbox"/> Family history of childhood hearing loss			
<input type="checkbox"/> Illness or condition requiring 5 days or greater in NICU		<input type="checkbox"/> Ototoxic medications <input type="checkbox"/> Craniofacial anomalies	
<input type="checkbox"/> Syndrome/stigmata associated with hearing loss		<input type="checkbox"/> In utero infection (TORCHS) <input type="checkbox"/> Other: _____	
<b>Transfer Information</b> (Indicate location and date transferred) <input type="checkbox"/> Reverse Transfer			
To:    Date:    (mm/dd/yyyy)		State (if not Ohio):	
From:    Date:    (mm/dd/yyyy)		State (if not Ohio):	

# 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](mailto: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