

****This form must be completed in full, please do not send charts, narratives, and/or diagrams****



Tennessee Department of Health
Newborn Screening Follow Up Program
8th Floor, Andrew Johnson Tower
710 James Robertson Parkway, Nashville, Tennessee 37243
Phone (855) 202-1357 Fax (615) 532-8555

Audiology Hearing Screen and/or Diagnostic Evaluation Results

Child's Last Name First Name Middle Name Gender Date of Birth

Birth Mother's Last Name First Name Maiden Name State Lab TDH#

Address City State/Zip Phone

Primary Care Provider Phone

Date of Evaluation: ____/____/____

Type of Evaluation: ABR/AABR OAE Tymp/Reflex ASSR Behavioral

➤ Results are **INCONCLUSIVE** and will Re-Evaluate on: ____/____/____

➤ Mark if: **Initial Screen** or **Re-Evaluation** **Results: R:** Pass Refer **L:** Pass Refer

➤ **Diagnostic Results:** Normal Limits (0-15dB) R L Hearing Loss R L

If Hearing Loss, Degree (please mark):

Slight (16-25dB) R L
Mild (26-40dB) R L
Moderate (41-55dB) R L
Moderately Severe (56-70dB) R L
Severe (71-90dB) R L
Profound (91+dB) R L

If Hearing Loss, Type (please mark):

Unspecified HL R L
Mixed HL R L
Sensorineural HL (including Fluctuating) R L
Auditory Neuropathy/Dyssynchrony R L
Permanent Conductive HL R L
Fluctuating Conductive HL R L

Comments: _____

Facility Name: _____ City: _____

Person filling out form (print name): _____

Risk Factors: (see below, check all that apply)

- | | | | | | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> A | <input type="checkbox"/> B | <input type="checkbox"/> C | <input type="checkbox"/> D | <input type="checkbox"/> E | <input type="checkbox"/> F |
| 1. NICU > 5 days | | | | | | A. Chemotherapy | | | | | |
| 2. Syndrome associated with progressive or late onset HL | | | | | | B. Assisted ventilation | | | | | |
| 3. Family history of permanent childhood hearing loss | | | | | | C. Ototoxic medications or loop diuretics | | | | | |
| 4. Craniofacial anomalies including those that involve the pinna, ear canal, ear tags, ear pits or temporal bone anomalies | | | | | | D. Hyperbilirubinemia requiring exchange transfusion | | | | | |
| 5. In-utero infections such as CMV, Herpes, Rubella, Syphilis, & Toxoplasmosis | | | | | | E. Physical findings such as white forelock associated with syndromes known to include SNHL or permanent conductive HL | | | | | |
| 6. ECMO | | | | | | F. Postnatal culture-positive infections associated with SNHL, including confirmed bacterial and viral (especially Herpes & Varicella), meningitis | | | | | |

Please COMPLETELY FILL OUT THIS FORM and fax to the Newborn Screening Program at 615-532-8555