****This form must be completed in full. Please do not send charts, narratives, and/or diagrams as they will be returned****

Tennessee Department of Health
Newborn Screening Follow Up Program
1st Floor, R.S. Gass Building
630 Hart Lane, Nashville, Tennessee 37216
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 | (Twin: A or B) | Date of Birth ___/___/___

Birth Mother's Last Name | First Name | Maiden Name | **State Lab TDH#** ( )

Address | City ( ) | State/Zip | Phone

Primary Care Provider Full Name | Phone | Foster Parent Name if Applicable

Birth Hospital Name: _____ City/State: _____

Date of Evaluation: _____/_____/_____

Type of Evaluation: □**ABR Click** □**ABR Tone Burst** □**DPOAE** □**TEOAE** □**ASSR** □**Tymp 1000 HZ** □**Tymp-Other** □**BT-Sound field** □**BT Earphone** □**BT- Bone Conduction** □**Reflexes**

Mark: **Initial Screen** ☐ **Follow-Up Screen** ☐ **Diagnostic** ☐ (provide Diagnostic results at bottom of page)

Results: R: ☐Pass ☐Fail **L:** ☐Pass ☐Fail

Only mark one box below:

☐ Results are **INCONCLUSIVE**

☐ Probable Acute Fluctuating Conductive HL - No TDH Referrals needed at this time
Re-Evaluate on: _____/_____/_____

NOTE: If hearing loss is marked below, **referrals for TEIS, CSS, Genetics, and Family Support WILL BE MADE.**

□ **Diagnostic Results:** Normal Limits (0-15dB) ☐**R** ☐**L or** Hearing Loss ☐**R** ☐**L** (if HL provide degree and type)

If Hearing Loss, Degree (please mark):			**If Hearing Loss, Type (please mark)**:	
Slight	(16-25dB)	☐**R** ☐**L**	Unspecified HL	☐**R** ☐**L**
Mild	(26-40dB)	☐**R** ☐**L**	Chronic Fluctuating Conductive HL	☐**R** ☐**L**
Moderate	(41-55dB)	☐**R** ☐**L**	Permanent Conductive HL	☐**R** ☐**L**
Moderately Severe	(56-70dB)	☐**R** ☐**L**	Mixed HL	☐**R** ☐**L**
Severe	(71-90dB)	☐**R** ☐**L**	Sensorineural HL (including Fluctuating)	☐**R** ☐**L**
Profound	(91+dB)	☐**R** ☐**L**	Auditory Neuropathy/Dyssynchrony	☐**R** ☐**L**

Comments/Follow-Up: _____
Facility/Provider Name: _____ Phone: (___)_____
Facility/Provider Address: _____

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ A ☐ C ☐ D ☐ F

1. **NICU >5 Days**
2. **Syndrome associated with progressive or late onset HL**
3. **Family history of permanent childhood hearing loss**
4. **Birth conditions or findings including microtia/atresia, ear dysplasia, cleft lip and/or palate, temporal bone abnormalities, white forelock, microphthalmia, congenital microcephaly, congenital or acquired hydrocephalus.**
5. **In-utero infections, such as CMV, Herpes, Rubella, Syphilis and Toxoplasmosis; Zika + Infant**
6. **ECMO**
7. **Asphyxia or Hypoxic Ischemic Encephalopathy**

A. **Events associated with hearing loss including significant head trauma, (especially basal skull/temporal bone fractures) or chemotherapy**
C. **Aminoglycoside administration >5 days**
D. **Hyperbilirubinemia requiring exchange transfusion**
F. **Postnatal culture-positive infections associated with Sensorineural Hearing Loss, including confirmed bacterial and viral (especially Herpes virus and Varicella) meningitis and encephalitis**