Universal Newborn Hearing Screening Program
Commission for Children with Special Health Care Needs
310 Whittington Parkway, Suite 200
Louisville, KY 40222
502-429-4430 or 1-877-757-4327
Fax 502-429-4489

Hearing Screen Report

Please Print or Type Information

Screen ID: 0

Information on this form is required by KRS 211.647

Baby's Name (Last, First, Middle)	DOB	Sex	Multiple

Adoption: ☐ Yes ☐ No Placed in Foster Care: ☐ Yes ☐ No	Foster Parent Information (Name/Full Address/Telephone)

Mother/Legal Guardian's Name (Last, First, Maiden/Middle)	Mother/Legal Guardian's SSN
Father/Legal Guardian's Name (Last, First, Middle)	Father/Legal Guardian's SSN

Address (Full mailing address including lot, apt or PO Box information)	City	State	Zip

Telephone # _____ ☐ Please indicate if spoken English is not the family's primary language. If not, please specify _____

The Universal Newborn Hearing Screening Program has been explained to me. I understand that I may receive information about follow-up testing for my child from the UNHS office.

Check One: ☐ Yes ☐ No *(Parent/Guardian Signature)* _____

Pediatrician's Name	Mailing Address		
City	State	Zip	Telephone #

Check if Infant History Includes: ☐ Birthweight < 2500 g ☐ Anoxia ☐ 5 Minute Apgar Score Less than or Equal to 3

THE FOLLOWING CRITERIA INDICATE A RISK FACTOR FOR LATE-ONSET AND/OR PROGRESSIVE HEARING LOSS. PLEASE CHECK AS APPROPRIATE.

☐ INFANT HAD BILIRUBIN LEVEL EQUAL TO OR GREATER THAN 18 MG *(List highest level)* _____	☐ INFANT DIAGNOSIS OF PERSISTENT PULMONARY HYPERTENSION
☐ CRANIOFACIAL ANOMALY/SYNDROME *(Specify)* _____	☐ INFANT DIAGNOSIS OF CYTOMEGALOVIRUS
☐ INFANT DIAGNOSIS OF SEPSIS	☐ MOTHER PRE/PERINATAL DIAGNOSIS OF CYTOMEGALOVIRUS
☐ INFANT DIAGNOSIS OF SEIZURES	☐ MOTHER PRE/PERINATAL DIAGNOSIS OF SYPHILIS
☐ INFANT DIAGNOSIS OF MENINGITIS	☐ MOTHER PRE/PERINATAL EXPOSURE TO RUBELLA
☐ OTOTOXIC MEDICATIONS (INCLUDING BUT NOT LIMITED TO AMINOGLYCOSIDES) USED FOR FIVE DAYS OR LONGER; AND/OR LOOP DIURETICS USED IN COMBINATION WITH AMINOGLYCOSIDES.	☐ FAMILY HISTORY OF PERMANENT CHILDHOOD HEARING LOSS (Excludes acquired hearing losses) *(Specify)* _____

HEARING SCREEN RESULTS

Date of screen: _____ **LEFT EAR** _____ **RIGHT EAR** _____

_____ Screener's Initials *(Voluntary)*

If not screened, please explain why: _____

Outpatient screening scheduled (not passing screen and/or marked risk): Date: _____ Time: _____ Location: _____

PARENT'S (OR LEGAL GUARDIAN) COUNTY OF RESIDENCE _____

BIRTH HOSPITAL _____ ☐ CHECK IF HOME BIRTH

DISCHARGE HOSPITAL _____ ☐ CHECK IF PLACED IN NICU

DATE OF INFANT'S DISCHARGE _____

INFANT WAS: *(Check One)* ☐ SENT HOME ☐ TRANSFERRED ☐ EXPIRED

IF TRANSFERRED, PLEASE GIVE HOSPITAL _____

_____ Signature of Hospital UNHS Staff
(I recognize the risk factors have been reviewed)