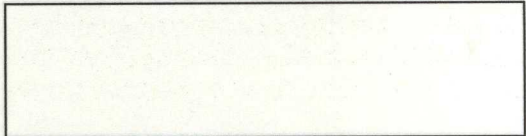




**Pennsylvania Department of Health  
NEWBORN HEARING SCREENING PROGRAM  
SCREENING REPORTING FORM**



**Instructions: Complete one form for each newborn.**

- If newborn passes initial screening, retain Medical Record Copy for completion of monthly statistical report.
- For each newborn **NOT** passing an initial or follow-up screening within 30 days of birth, or is a "NO SHOW" for an appointment **FAX COPY OF THIS FORM** to: **Newborn Hearing Screening Program** at **(717) 705-9386**.
- If you have questions, or require additional forms, please call the Department of Health (DOH) at (717) 783-8143.
- **FAX ANOTHER COPY TO THE INFANT'S PRIMARY CARE PROVIDER.**

**HOSPITAL** (Screening Facility): \_\_\_\_\_ **Hospital 4-digit code:** \_\_\_\_\_

**MOTHER'S FULL NAME:** \_\_\_\_\_

**BABY'S FULL NAME AFTER DISCHARGE:** \_\_\_\_\_

**SEX:** M  F

**DOB:** \_\_\_\_\_  
MM/DD/YY

**Primary Language:**  English  Spanish  
 Other \_\_\_\_\_

**County of Residence:** \_\_\_\_\_

**NICU: YES NO**

**FILTER PAPER #** \_\_\_\_\_

HEARING TEST	DATE TEST GIVEN MM/DD/YY	RESULTS (circle one) P= Pass; NP=Not Pass; NS=No Show	DATE PCP NOTIFIED MM/DD/YY	DATE FAMILY NOTIFIED MM/DD/YY
INITIAL SCREENING		Right Ear <b>P NP</b> Left Ear <b>P NP</b> <b>NS</b>		
HEARING TEST	DATE TEST GIVEN MM/DD/YY	RESULTS (circle one) P= Pass; NP=Not Pass; NS=No Show	DATE PCP NOTIFIED MM/DD/YY	DATE FAMILY NOTIFIED MM/DD/YY
FOLLOW-UP RESCREEN		Right Ear <b>P NP</b> Left Ear <b>P NP</b> <b>NS</b>		

**\*\*\* Please complete the below information in full prior to submitting referral to DOH \*\*\***

**PARENT INFORMATION**

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Email:** \_\_\_\_\_

Adoptive Parent(s)  Foster Parent(s)

**ALTERNATE CONTACT**

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

**Relationship to baby:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AFTER DISCHARGE**

**PRIMARY CARE PROVIDER**

**Name:** \_\_\_\_\_

**Practice:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX:** \_\_\_\_\_

**PA STATE GUIDELINES: Re-screen by 1 month of age, Diagnostic Evaluation by 3 months, Linkage to Early Intervention Services by 6 months if hearing loss is detected. PA Department of Health, Division of Newborn Screening and Genetics, 625 Forster Street, Health & Welfare Building Harrisburg, PA 17120**

**Screening Facility/Medical Record Copy (2<sup>nd</sup> page Parent Copy)**