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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES — NEWBORN HEARING SCREENING RESULTS REPORT — EOAA EMPLOYER

DISTRIBUTION: WHITE - DHSS; **YELLOW** - SUBMITTER

HOSPITAL-PATIENT LABEL

1. BABY'S NAME (LAST, FIRST)

2. DATE OF BIRTH TIME :

3. BIRTHING FACILITY NAME

4. BABY'S MEDICAL RECORD NUMBER

5. MOTHER'S MEDICAL RECORD NUMBER

6. MOTHER'S NAME (LAST, FIRST)

7. MOTHER'S STREET ADDRESS/P.O. BOX

8. CITY

9. STATE

10. ZIP CODE

11. MOTHER'S TELEPHONE NUMBER

12. ALTERNATE TELEPHONE NUMBER

13. BABY'S PRIMARY CARE PHYSICIAN (LAST, FIRST) OR CLINIC

FOR HEARING SCREENING ONLY

14. TYPE OF SCREENING *(check only one)* ☐ INITIAL ☐ RESCREEN

17. SEX ☐ MALE ☐ FEMALE

18. GESTATION AGE WEEKS ___ ___

15. BIRTH ORDER *(Enter A – F, S = Single)*

19. BIRTH WEIGHT _____ grams/lbs. oz.

16. REASON NOT SCREENED
☐ DECEASED
☐ REFUSED
☐ TRANSFER TO: _____

20. HEARING SCREENING RESULTS

LEFT EAR		RIGHT EAR	
☐ ABR	☐ PASS	☐ ABR	☐ PASS
☐ OAE	☐ REFER	☐ OAE	☐ REFER
☐ MISSED	DATE SCREENED _____	☐ MISSED	DATE SCREENED _____
☐ OTHER _____		☐ OTHER _____	

21. RISK FACTORS:
- ☐ NICU STAY MORE THAN 5 DAYS
- ☐ FAMILY HISTORY OF PERMANENT CHILDHOOD HEARING LOSS
- ☐ IN-UTERO INFECTION
- ☐ SYNDROME ASSOCIATED WITH HEARING LOSS
- ☐ NEURODEGENERATIVE DISORDER
- ☐ CULTURE-POSITIVE POSTNATAL INFECTION ASSOCIATED WITH HEARING LOSS
- ☐ OTOTOXIC MEDICATIONS

COMPLETE SUBMITTER NAME, ADDRESS, TELEPHONE & FAX #
OR AFFIX SUBMITTER LABEL

MO 580-9012 (2-15)

INSTRUCTIONS – NEWBORN HEARING SCREENING REPORTING FORM

GENERAL

Use this form to report identifying information and initial hearing screening or rescreening results.
Submit white copy to the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. All hearing screening reports must be reported **no more than seven (7) days following the completion of the initial hearing screening or any rescreening. Complete the lower right hand box with submitter information, or if available, affix submitter label.**

SPECIFIC INSTRUCTIONS

ITEM

1. BABY'S NAME: Enter baby's complete name, if known.
2. BABY'S DATE AND TIME OF BIRTH: Enter baby's date of birth as MM/DD/YY, and time of birth in military time (i.e. 1:00 pm is 13:00 hrs).
3. BIRTHING FACILITY NAME: Enter the name of facility where baby was born.
4. BABY'S MEDICAL RECORD NUMBER: Enter medical record number, if available.
5. MOTHER'S MEDICAL RECORD NUMBER: Enter number.
6. MOTHER'S NAME: Enter mother's first and last name.
7. MOTHER'S STREET ADDRESS: Enter mother's street address.

8-10. MOTHER'S CITY, STATE, ZIP CODE: Enter all available information.

11. MOTHER'S PHONE NUMBER: Enter current area code and phone number.
12. ALTERNATE TELEPHONE NUMBER: Enter alternate phone number, if available.
13. BABY'S PRIMARY CARE PHYSICIAN OR CLINIC: Enter the name of the primary care physician that will undertake the care of the baby following discharge.
14. TYPE OF SCREENING: Check the type of screening. **Initial** hearing screenings are those hearing screenings performed during the birth admission, prior to hospital discharge. A **rescreen** is any hearing screening performed on an outpatient basis. Exceptions include an initial hearing screening "missed" or not performed during the birth admission due to equipment problems, environment disturbances, or early discharge. In these exceptions, check initial.
15. BIRTH ORDER OF MULTIPLE BIRTHS: Enter "S: for single birth, and "A-F" to designate birth order.
16. REASON NOT SCREENED: Check reason not screened.
17. SEX: Check applicable sex.
18. GESTATION AGE: Enter gestation age at birth in weeks.
19. BIRTH WEIGHT: Enter weight at birth in grams or pounds and ounces.
20. HEARING SCREENING RESULTS: Check the method used to perform the most recent hearing screening for the right ear and the left ear. Check pass or refer for each ear and record the date of the most recent screening for each ear. Check missed if you are unable to perform the hearing screening at this time.
21. RISK FACTORS: Check all that apply.