WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
Office of Maternal, Child and Family Health
dhhr.wv.gov/bph
Toll Free: 1-800-642-8522

NEWBORN HEARING SCREENING PROJECT

Early Hearing Detection and Intervention (EHDI) Reporting Form

Mail or Fax Completed Reporting Form Within 10 Days of Visit to:
Mail: Newborn Hearing Screening Project, 350 Capitol Street, Room 427, Charleston, WV 25301 Fax: 304-558-3510

1

Child's Name: | Date of Birth: | Sex: ☐ Female ☐ Male | Birth Hospital/Facility: | Transfer Hospital/Facility:

Street Address: | City: | State: | Zip Code:

Name of Parent/Guardian: ☐ Mother ☐ Father ☐ Other _____ | Name of Child's Physician:

Phone Number: | Email: | Phone Number: | Fax Number:

Name of Parent/Guardian: ☐ Mother ☐ Father ☐ Other _____ | Street Address:

Phone Number: | Email: | City: | State: | Zip Code:

I,_____, give permission to share these results with my child's primary care provider, the West Virginia Newborn Hearing Screening (NHS) Project, and West Virginia Hands & Voices (WVH&V) to ensure medical, educational, and audiological services are made available to my child in an appropriate and timely manner.

Signature of Parent/Legal Guardian: _____ **Date:** _____

Family History of Hearing Loss: ☐ Yes ☐ No ☐ Unsure If yes, who:

Reason for Follow-up:
☐ Not Screened Previously ☐ Refer Result on Previous Screen ☐ AABR ☐ Right Ear ☐ Left Ear ☐ OAE ☐ Right Ear ☐ Left Ear
☐ Hospital Readmission in 1st Month for:
☐ Hyperbilirubinemia w/exchange transfusion ☐ Culture positive sepsis
☐ Other hospitalization (reason): _____
☐ Risk Indicator follow-up (see instructions for codes): _____

2

Name and Address of Outpatient Screening/Audiologic Evaluation Facility:

Name of Evaluator: | Telephone Number: | Date of Exam:

3

OUTPATIENT SCREENING RESULTS AND RECOMMENDATIONS

Screening Assessment(s) Results:

☐ OAE		☐ AABR	
Right Ear	Left Ear	Right Ear	Left Ear
☐ Pass	☐ Pass	☐ Pass	☐ Pass
☐ Fail	☐ Fail	☐ Fail	☐ Fail

Screening Recommendations:
☐ Pass – No further evaluation required unless future physician or parental concern
☐ Pass with risk indicator – Refer for complete audiologic according to JCIH 2019 Guidelines
☐ Fail – Refer for complete audiologic evaluation
☐ Referral to physician with re-screening following medical intervention
☐ Aural atresia – Refer for complete audiologic evaluation

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AUDIOLOGICAL EVALUATION

Diagnostic Assessment:
☐ ABR
☐ ASSR
☐ Behavioral Observation
☐ DPOAE/TEOAE
☐ Tympanometry

Hearing Loss Type:

Right	Left	
☐	☐	Hearing Within Normal Limits
☐	☐	Conductive Hearing Loss (transient)
☐	☐	Conductive Hearing Loss (permanent)
☐	☐	Sensorineural Hearing Loss
☐	☐	Mixed Hearing Loss (SN/trans. cond.)
☐	☐	Mixed Hearing Loss (SN/perm. cond.)
☐	☐	Auditory Neuropathy
☐	☐	Inconclusive

Hearing Loss Degree/Range:

Right	Left		
☐	☐	Normal	-10 to15 dB
☐	☐	Slight	16 to 25 dB
☐	☐	Mild	26 to 40 dB
☐	☐	Moderate	41 to 55 dB
☐	☐	Moderately Severe	56 to 70 dB
☐	☐	Severe	71 to 90 dB
☐	☐	Profound	91+ dB

Next Appointment:
☐ None required, unless future physician or parental concern ☐ Audiologic Evaluation for Risk Indicator monitoring
☐ Follow-up appointment for_____
Date:_____Time:_____If additional testing is to be performed at a different facility, please indicate facility:_____

REFERRED TO WEST VIRGINIA BIRTH TO THREE (BTT) ☐ YES ☐ NO ☐ INFANT IS CURRENTLY ENROLLED IN BTT

Additional Recommended Referral(s) (Check all that apply):
☐ Pediatrician ☐ Ophthalmologist ☐ Hearing Aid Services ☐ Otolaryngologist
☐ Parent Support Services ☐ Genetics Evaluation ☐ Craniofacial/Cleft Center ☐ Other:_____

Comments:

Distribution: ☐ Original-NHS ☐ Copy-Family ☐ Copy-Primary Care Provider