# Hearing Diagnostic Report

Child's Name: _____ (Last, First) Birth Name: _____ (Last, First) DOB: _____

Mother's Name: _____ (Last, First) Email: _____ Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ Phone: _____ ☐ Home ☐ Cell ☐ Work

City: _____ State: _____ County: _____ Zip Code: _____

Primary Care Provider/Pediatrician: _____ Phone: _____

Referral Source: _____ Insurance/Medicaid #: _____

## Newborn Hearing Screening:

Results: ☐ Pass ☐ Refer ☐ Not Screened | Birth Hospital:

## Risk Factors for hearing loss: ☐ NA

- ☐ Caregiver concern
- ☐ Head trauma
- ☐ In-utero infection(s)
- ☐ Craniofacial anomalies
- ☐ Family history of hearing loss
- ☐ Neurodegenerative disorder
- ☐ Hyperbilirubinemia with transfusion
- ☐ ECMO assisted ventilation
- ☐ Physical findings/syndrome associated with hearing loss
- ☐ Postnatal infection associated with hearing loss
- ☐ Ototoxic medications/loop diuretic/chemotherapy
- ☐ NICU/PICU/PCICU > 5 days (*Number of days:* _____)

## Evaluation Procedures: ☐ Unable to Evaluate ☐ Refused Evaluation

Date: _____

- ☐ Initial appointment
- ☐ Follow-up Appointment
- ☐ Did not show

- ☐ Air Conduction ABR
- ☐ Bone Conduction ABR
- ☐ Click
- ☐ Tone Bursts
- ☐ Acoustic Immittance
  - ☐ Tympanometry
  - ☐ Acoustic Reflex
  - ☐ Wideband
- ☐ Otoacoustic Emissions
- ☐ Visual Reinforcement Audiometry
- ☐ Auditory Steady-State Response

## Confirmed Hearing Status: *Indicate for each ear*

☐ Preliminary results: Additional testing required for confirmation of hearing loss

| LEFT EAR | | RIGHT EAR | |
|---|---|---|---|
| ☐ Normal (-10 - 15 dB) | ☐ Ear Malformation* | ☐ Normal (-10 - 15 dB) | ☐ Ear Malformation* |
| *Degree of Hearing Loss* | *Type of Hearing Loss* | *Degree of Hearing Loss* | *Type of Hearing Loss* |
| ☐ Slight (16 - 25 dB) | ☐ Nontransient Conductive | ☐ Slight (16 - 25 dB) | ☐ Nontransient Conductive |
| ☐ Mild/Minimal (26 - 40 dB) | ☐ Transient Conductive | ☐ Mild/Minimal (26 - 40 dB) | ☐ Transient Conductive |
| ☐ Moderate (41 - 55 dB) | ☐ Sensorineural | ☐ Moderate (41 - 55 dB) | ☐ Sensorineural |
| ☐ Moderately Severe (56 - 70 dB) | ☐ Mixed | ☐ Moderately Severe (56 - 70 dB) | ☐ Mixed |
| ☐ Severe (71 - 90 dB) | ☐ ANSD | ☐ Severe (71 - 90 dB) | ☐ ANSD |
| ☐ Profound (>90 dB) | | ☐ Profound (>90 dB) | |

## Recommended Follow-up:

☐ within 1 month ☐ 3 months ☐ 6 months ☐ 12 months | Date: _____

## Referral:

- ☐ MS First Steps Early Intervention (*Any degree or type of hearing loss, including unilateral loss, must be referred.*)
- ☐ Medical provider: _____ Appt. Date/Time: _____
- ☐ Second opinion: _____ Appt. Date/Time: _____
- ☐ Evaluation for amplification: _____ Appt. Date/Time: _____

## Comments: *Please note any ear malformations (atresia, microtia, ear canal stenosis) or other relevant factors*

Name: _____ Facility: _____ Date: _____

**Fax/Mail to Mississippi State Department of Health or submit electronically via MS-HIN within 48 hours:**


Mail: Early Hearing Detection and Intervention Program
570 East Woodrow Wilson, O-204
P.O. Box 1700, Jackson, Mississippi 39215-1700

Phone: 1-800-451-3903 / 601-576-7427

Fax: 601-576-7540



*Form No. 53*
*Revised 12-15-2016*

# Hearing Diagnostic Report – Form 53

Instructions

## PURPOSE

This form is intended to document and report the hearing diagnostic status of newborns/infants to the Mississippi State Department of Health.

## INSTRUCTIONS

1. The *Hearing Diagnostic Report* form must be completed for all children ages birth to three years to enable appropriate follow-up and support in the following situations:
   a. The child was evaluated due to referral on a hearing screening.
   b. The child was present for the appointment but was not able to be evaluated for any reason (e.g., the evaluation device was broken or the child could not comply with the evaluation procedures).
   c. The family failed to return for a scheduled hearing appointment (i.e., no show).
   d. The family refused to have a hearing diagnostic evaluation conducted.
2. The *Hearing Diagnostic Report* form should be mailed, faxed, or sent electronically through the Mississippi Health Information Network (MS-HIN) **within 48 hours** of an appointment or event necessitating a report (e.g., missed appointment or refusal).

   **Fax:** (601) 576-7540
   **Mail:** Mississippi State Department of Health
   Early Hearing Detection and Intervention
   P.O. Box 1700
   Jackson, MS 39215-1700
   **MS-HIN:** msdh-ehdi@ms-hin.medicity.net

**Please check the appropriate box and/or print the requested information in the space provided.**

### Demographic Data

- **Child Name:** Record the child's *current* last and first name.
- **Birth Name:** Record the child's last and first name *at birth*.
- **Date of Birth:** Record the month, day, and year the child was born.
- **Mother's Name:** Record the mother's current last and first name.
- **Email:** Record the mother's (or other parent/primary caregiver's) email address.
- **Phone:** Record the mother's (or other parent/primary caregiver's) area code and telephone number. Check the appropriate box to indicate the type of phone number recorded: Home, Cell, or Work.
- **Address:** Record the mother's (or other parent/primary caregiver's) mailing address.
- **Phone:** Record the mother's (or other parent/primary caregiver's) alternate area code and telephone number. Check the appropriate box to indicate the type of phone number recorded: Home, Cell, or Work.
- **City:** Record the mother's (or other parent/primary caregiver's) mailing address city.
- **State:** Record the mother's (or other parent/primary caregiver's) mailing address state.
- **County:** Record the mother's (or other parent/primary caregiver's) mailing address county.
- **Zip Code:** Record the mother's (or other parent/primary caregiver's) mailing address zip code.
- **Primary Care Provider/Pediatrician:** Record the name of the child's primary care provider or pediatrician.
- **Phone:** Record the primary care provider's or pediatrician's area code and telephone number.
- **Referral Source:** Record the name of the individual or facility (e.g., birthing hospital) that referred the child for an evaluation.
- **Insurance/Medicaid #:** Record the individual or group insurance number for the child.

**Newborn Hearing Screening**

- **Results:** Check the appropriate box to indicate the hearing screening results:
  - **Pass:** Check the box if the child passed for both ears on the most recent hearing screening.
  - **Refer:** Check the box if the child referred for either or both ears on the most recent hearing screening.
  - **Not Screened:** Check the box if the child did not have a hearing screening conducted prior to a diagnostic evaluation.
- **Birth Hospital:** Record the name of the hospital where the child was born. If the child was not born in a hospital, enter the name of the facility or location of birth.

**Risk Factors for Late Onset Hearing Loss** (Check *all* that apply. If none of these risk factors apply, check "NA" for *not applicable*.)

- **Caregiver concern:** Check the box if the child's parent or primary caregiver has expressed a concern about the child's hearing, speech, language, or development.
- **Family History of Hearing Loss:** Check the box if the child has a family member with a history of permanent childhood hearing loss.
- **Physical findings/Syndrome associated with Hearing Loss:** Check the box if the child has a syndrome associated with hearing loss or progressive/late onset hearing loss (e.g., neurofibromatosis, osteopetrosis, or Usher, Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson syndromes) or physical characteristics associated with sensorineural or permanent conductive hearing loss (e.g., white forelock).
- **Head Trauma:** Check the box if the child received any head trauma, especially a basal skull/temporal bone fracture requiring hospitalization.
- **Neurodegenerative disorder:** Check the box if the child has a neurodegenerative disorders (e.g., Hunter syndrome) or sensory motor neuropathies (e.g., Friedreich's ataxia and Charcot-Marie-Tooth syndrome).
- **Postnatal infection associated with Hearing Loss:** Check the box if the child has had a positive culture for a postnatal infection associated with sensorineural hearing loss, including confirmed bacterial and viral meningitis, especially herpes and varicella varieties.
- **In-utero infection(s):** Check the box if the child was exposed to infections such as cytomegalovirus (CMV), herpes, rubella, syphilis, and toxoplasmosis in-utero.
- **Hyperbilirubinemia with transfusion:** Check the box if the child received a transfusion as a result of hyperbilirubinemia.
- **Ototoxic medications/loop diuretic/chemotherapy:** Check the box if the child was exposed to ototoxic medications (e.g., gentamicin and tobramycin), loop diuretics (e.g., furosemide/lasix), or chemotherapy drugs.
- **Craniofacial anomalies:** Check the box if the child has any craniofacial anomalies, including pinna, ear canal, ear tags, ear pits, and temporal bone anomalies.
- **ECMO assisted ventilation:** Check the box if the child received extracorporeal membrane oxygenation (ECMO) assisted ventilation.
- **NICU/PICU/PCICU > 5 Days (Number of days: _____):** Check the box if the child spent more than five (5) calendar days in the NICU/PICU/PCICU. Record the total number of days the infant was hospitalized in the NICU/PICU/PCICU.

**Evaluation Procedures**

**Please print the appointment date in the space provided and check the appointment type.**

- **Date:** Record the month, day, and year of the appointment.
- **Initial Appointment:** Check the box if the appointment is an initial diagnostic evaluation.
- **Follow-up Appointment:** Check the box if the appointment is a follow-up diagnostic evaluation.
- **Did not show:** Check the box if the family was not present for a scheduled hearing appointment.

**If the evaluation was not completed, please check the appropriate box.**

- **Unable to Evaluate:** Check the box if the child was present for the appointment but was not able to be evaluated for any reason (e.g., the evaluation device was broken or the child could not comply with the evaluation procedures).
- **Refused Evaluation:** Check the box if the family refused to have a hearing evaluation conducted.

**Please check the appropriate boxes for the procedures conducted. Check *all* that apply.**

- **Air Conduction ABR:** Check the box if the evaluation includes an air conduction auditory brainstem response (ABR) procedure.
- **Bone Conduction ABR:** Check the box if the evaluation includes a bone conduction auditory brainstem response (ABR) procedure.
- **Click:** Check the box if the ABR procedure use clicks for stimuli.
- **Tone Bursts:** Check the box if the ABR procedure use tone bursts for stimuli.
- **Acoustic Immittance:** Check the box if the evaluation includes measures of acoustic immittance. If so, indicate the method(s):
  - **Tympanometry:** Check the box if the evaluation includes tympanometry procedures.
  - **Acoustic Reflex:** Check the box if the evaluation includes acoustic reflex (thresholds/decay) testing.
  - **Wideband:** Check the box if the evaluation includes Wideband Acoustic Immittance (WAI) testing.
- **Otoacoustic Emissions:** Check the box if the evaluation includes otoacoustic emission (OAE) procedures.
- **Visual Reinforcement Audiometry:** Check the box if the evaluation includes visual reinforcement audiometry (VRA) behavioral assessment procedures.
- **Auditory Steady-State Response:** Check the box if the evaluation includes an auditory steady-state response (ASSR) procedure.

**Confirmed Hearing Status**

**If the results are not a confirmation of hearing loss, please check the appropriate box.**

- **Preliminary results:** Check the box if the evaluation results are preliminary and additional testing will be required for confirmation of hearing loss.

**To record results for the left and right ear, please check the appropriate box.**

- **Normal:** Check the box if the child's hearing falls within normal limits using American Speech-Language-Hearing Association (ASHA) criteria.
- **Ear Malformation:** Check the box if the child has any form of ear malformation (e.g., atresia, microtia, or ear canal stenosis). Please provide additional details within the comment section.
- **Degree of Hearing Loss:** Check the appropriate box to indicate the degree of hearing loss for each ear using ASHA criteria: Slight, Mild/Minimal, Moderate, Moderately Severe, Severe, and Profound.
- **Type of Hearing Loss:** Check the appropriate box to indicate the type of hearing loss for each ear: Nontransient Conductive, Transient Conductive, Sensorineural, Mixed Conductive and Sensorineural, and Auditory Neuropathy Spectrum Disorder (ANSD).

**Recommended Follow-up** (if applicable)

- **Follow-up:** Check the appropriate box to indicate the timeframe for a scheduled subsequent diagnostic evaluation: Within 1 month, in 3 months, in 6 months, or in 12 months.
- **Date:** Record the month, day, and year of the scheduled follow-up appointment.

**Referrals** (if applicable)

- **MS First Steps Early Intervention:** Check the box to indicate if the child was referred to the Mississippi First Steps Early Intervention Program.

- **Medical provider:** Check the box if the child was referred to a primary or specialist medical provider for follow-up screening, evaluation, and/or treatment. Record the name of the medical provider and the month, day, year, and time of the scheduled appointment.
- **Second opinion:** Check the box if the child was referred to another audiologist for another diagnostic evaluation. Record the name of the audiologist and the month, day, year, and time of the scheduled appointment.
- **Evaluation for amplification:** Check the box if the child was referred for an evaluation for amplification devices. Record the name of the medical provider and the month, day, year, and time of the scheduled appointment.

***NOTE: Any child with <u>any</u> degree or type of hearing loss, including unilateral loss, <u>must</u> be referred for early intervention.***

- **<u>Comments</u>** Record any additional information relevant for follow-up, including information about ear malformations, not included above.

**<u>Reporting Source</u>**
- **Name:** Record the name of the diagnostician completing the report.
- **Facility:** Record the name of the facility that conducted the hearing evaluation.
- **Date:** Record the month, day, and year the report was completed.

## <u>OFFICE MECHANICS AND FILING</u>

After the *Hearing Diagnostic Report* form is completed, a copy should be mailed, faxed, or sent electronically through the Mississippi Health Information Network (MS-HIN) **<u>within 48 hours</u>** to the Mississippi State Department of Health (MSDH). In addition, a copy should be placed in the child's medical record. Copies should also be forwarded to the child's primary care provider and any outside referral (e.g., early intervention, medical provider, or audiologist).

The MSDH Early Hearing Detection and Intervention (EHDI) Program will enter this information into the EHDI database and place this report in the child's EHDI file.

## <u>RETENTION PERIOD</u>

The MSDH-EHDI Program will retain this report for five years. Other agencies, facilities, and medical providers will retain this report according to their applicable patient records retention policy.