



Early Hearing Detection and Intervention (EHDI): Audiologist Follow-up Report

Child's Name: _____ Birth Hospital Med. ID _____

Other Names the Infant May be Known as: _____

Mother's Maiden Name or Mother's Last Name at Time of Infant's Birth: _____

Date of Birth _____ Sex: Male Female

Birth Hospital _____ City: _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

(City) (State) (ZIP) (County) (Phone)

Infant's Primary Health Care Provider _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Audiologist Full Name
(please print) _____

Facility / Agency _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Is there family history of permanent childhood hearing loss? Yes No

List any known risk factors:

Notes:

Audiological Follow-up Report (Cont.)

Child's Name _____ **Testing Performed was:** **INPATIENT** **OUTPATIENT**

Date of this Evaluation _____ **Testing Performed was:** **SCREENING** **DIAGNOSTIC**

Tests (mark all that apply)	PER THE JOINT COMMITTEE ON INFANT HEARING: TESTING OF <u>BOTH</u> EARS SHOULD BE COMPLETED ON THE <u>SAME DAY</u>
DPOAE	Tympanometry 226 Hz
TEOAE	Tympanometry 1000 Hz
Automated ABR (AABR)	Acoustic Reflexes
ABR - Click ABR Tone Burst	Physical exam and/or review of medical records
ASSR	Other (Specify) _____

Diagnosis/ Type of Loss	Right	Left
Hearing within Normal Limits / PASS		
Sensorineural Loss		
Permanent Conductive Loss		
Mixed Loss		
Undetermined Type Loss / REFER comment: _____ _____		

Degree of Loss	Right	Left
Not Applicable		
Mild (26-40dB)		
Moderate (41-55dB)		
Moderately Severe (56-70dB)		
Severe (71-90dB)		
Profound (91+dB)		
Sloping (describe)		

Recommendations / Referrals (please indicate date(s) of referral(s) and date(s) of appointment(s))	Date
Early Intervention Services (EI) (date of referral)	
Division Of Specialized Care For Children (DSCC) (date of referral)	
Medical Referral (to whom?) (date of appointment)	
Amplification Evaluation (date of appointment)	
Other (specify)	

This form is required to adequately document results. More specific evaluation information may be submitted in addition.

Submit BOTH PAGES of this form to:

Illinois Department of Public Health
Early Hearing Detection and Intervention
 535 W. Jefferson St., 2nd floor
 Springfield, IL 62761
 217-782-4733

Reporting must be completed within 7 days of testing.
 This form may be faxed to: **217-557-5324** OR E-mailed to:
dph.hearingreports@illinois.gov