State of Illinois
Illinois Department of Public Health

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

Please Print

Child's Name ______________________ Med. ID ____________

Other names this infant may also be known as:

____

Date of Birth ____________________ Sex: ❑ Male ❑ Female

Birth Hospital ______________________________

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

Address ______________________________
(Street) (Apt.#)

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

Physician's **FULL** Name ______________________________

Phone ____________________ FAX ____________________

Screener's Name &Title ______________________________

Address ______________________________

Phone ____________________ Date Completed ____________________

PER THE JOINT COMMITTEE ON INFANT HEARING: TESTING OF BOTH EARS SHOULD BE COMPLETED ON THE SAME DAY

Screening Technology Used: ❑ Automated ABR ❑ DPOAE ❑ TEOAE

Screening Results:

Right Ear Result ❑ **Pass** ❑ **Refer**
Left Ear Result ❑ **Pass** ❑ **Refer**

Notes / Action plan:

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

This form may be faxed to: 217-557-5324
OR
E-mailed to: ***dph.hearingreports@illinois.gov***

IOCI 14-342 1/15 Printed by Authority of the State of Illinois