

Diagnostic Hearing Evaluation Form

Department of Health, Children's Medical Services (CMS), Newborn Screening Program

Complete this form ONLY for infants or toddlers – Fax to (850) 922-5385

*Audiology Clinic _____ *Audiologist Name _____ *Date of Visit _____

Demographic Information *(Items with an asterisk * are required)*

*Child's Name _____ *Child's DOB ___/___/___ Gender: _____

Child's Race ___ African American ___ Caucasian ___ Hispanic ___ Haitian ___ Asian/Pacific Islander ___ Native American ___ Unknown

*Birth Mother's Name *(if known)* _____ *Birth Hospital *(if known)* _____

*Street Address _____ *City _____ *Zip _____

County _____ *Home Phone _____ Other Phone _____

Primary Care Physician _____ Physician Phone _____

Audiological Evaluation Results

Level 1 - Diagnostic evaluation results from this visit (Please record Pass (P) or Fail (F):

	Diagnostic ABR	Bone Cond ABR	Tone Burst ABR 500	Tone Burst ABR 1000	Steady State ASSR	Diagnostic OAE	High Freq Immitance/Tympanogram	VRA	BOA
Right Ear	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F
Left Ear	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F	__ P __ F

Level 2 - Extent of hearing loss suspected (S) or confirmed (C) during this visit:

	None 16-25 dB	Mild 26-40 dB	Moderate 41-55 dB	Moderate-Severe 56-70 dB	Severe 71-90 dB	Profound > 90 dB	Sensori-Neural	Conductive	Mixed	Auditory Neuropathy
Right Ear	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C
Left Ear	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C	__ S __ C

*Referral and Follow-Up Information - At the conclusion of this visit, overall hearing status is considered

- Normal Hearing at this time
- Apparent middle ear effusion; return after medical treatment
- Apparent middle ear effusion; presence of sensorineural hearing loss is unlikely based on test battery results; child referred to physician
- No show for _____ appointment(s). Lost to Follow-up
- Hearing Loss has been confirmed during this visit****

**Referral to your local CMS Early Intervention Program (EIP) for Part C Services is required by law (CFA 303.321d) within 2 working days of hearing loss confirmation (not to include children with middle ear histories under age 12 months).

____ Date of referral to CMS-EIP _____: and

____ This submission requests CMS Newborn Screening Program to follow-up with the local CMS-EIP regarding this referral

Materials Requested from CMS Newborn Screening Program

____ One free **hearing aid listening test kit** for this family (up to age 3 only).
 Hearing aid listening kit instruction sheet language _____ English _____ Spanish _____ Creole

Send Early Intervention Program (EIP) and SHINE Brochures (early services for young children with hearing loss):

Number of EIP Brochures: _____ English _____ Spanish _____ Creole

SHINE Brochures: _____ English _____ Spanish _____ Creole

Person Completing Form: _____ Phone Number: _____

Children's Medical Services (CMS) - Newborn Screening Data System

Please complete the Follow-Up Diagnostic Evaluation Results Form for each visit for:

All infants and toddlers (birth to three) with CONFIRMED hearing loss of suspected or defined degree, and all Infants or toddlers with evidence of auditory neuropathy/dys-synchrony in both ears. The presence of confirmed hearing loss or auditory dys-synchrony allows the child to be eligible for early intervention services.

This form is intended to collect the results of a single visit. Please record only the extent of loss noted during this visit, and use additional forms to record subsequent visits.

Release of Protected Health Information without Authorization – Children's Medical Services, a division of the Florida Department of Health, administers the Newborn Screening Program, which includes hearing and metabolic screening. Newborn screening is an activity described in its capacity as a public health authority as defined by the HIPAA Standards for Privacy of Individually Identifiable Health Information, Final Rule (Privacy Rule). Pursuant to 45 CFR 164.512(b) of the Privacy Rule, covered entities such as your organization may disclose protected health information (PHI) to public health authorities. Public health entities are authorized to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and for the purpose of conducting public health surveillance, public health investigations, and public health intervention. For more information, visit the Center for Disease Control and Prevention site: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su5201a1.htm>.

Required Demographic Information – For the child's first visit to your facility, please complete all asterisked (*) demographic information to ensure that CMS Newborn Screening has a complete record. On subsequent visits only update the demographic information that may have changed (address, phone number, etc.).

Audiological Results –

Level 1 – Diagnostic Evaluation Results – Presence or Confirmation of Hearing Loss - *Referral to the local Early Intervention Program should occur after this point of confirmation of the hearing loss.*

Level 2 – Extent of Suspected or Confirmed Hearing – Please indicate whether hearing loss is SUSPECTED (S) or CONFIRMED (C) in the appropriate box(es).

Referral and Follow-Up Information – **Overall Hearing Status** – Select a single option that best represents the hearing status determined at the close of this visit.

Referral to CMS Early Intervention is Required by Federal Law (CFA 303.321d) An audiologist must refer an infant/family to the local early intervention program within 2 days of confirmation of hearing loss after audiological evaluation (presence of hearing loss, **do not wait for full threshold information**). Please indicate the date that your facility contacted the local CMS-EIP Center.

Who should not be referred to CMS-EIP?

Infants with middle ear histories under 12 months should not be referred, but toddlers with evidence of documented unresolved or chronically recurrent conductive hearing loss in combination with at least 4 of the following can be referred for possible intervention services:

- *4 or more episodes of otitis media in 12 months, primarily in both ears*
- *Single episode of otitis media lasting longer than 3 months; primarily in both ears*
- *Indication of fluctuating hearing loss (20 dB+ OR caregiver/physician report)*
- *Caregiver or physician concern over speech and/or language development (delayed speech/language milestones)*
- *Caregiver concern over behavioral response when child is given a direction or placed in new situations and child is more than 18 months.*

How to Request a Free Hearing Aid Test Kit – When amplification is recommended or fitted, a free hearing aid test kit for the child may be requested from CMS Newborn Screening Program by checking the appropriate box. To receive the free kit, the "language used in the home" must be indicated on the form so that the appropriate instruction sheet can be included. Please note that in order to receive a free kit:

- Families must receive a SHINE brochure;
- Families must be referred to a local Early Intervention Program (EIP); and
- The Newborn Screening data system must have received this data form.

The test kit will be mailed to your facility immediately upon receipt of this form. For more information regarding the SHINE Program or Hearing Aid Listening Kits, contact the CMS Newborn Hearing Screening program at (850) 245-4201.

Check the box for the hearing aid listening test kit.

Check the language spoken in the home box.

Request for Early Intervention or SHINE Brochures – Indicate if you would like to receive brochures describing early intervention in general, or describing early intervention specifically related to hearing loss. Specify the number of brochures in the different languages you would like to receive.