



# Early Hearing Detection and Intervention (EHDI): Audiological 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 \_\_\_\_\_

Date of this Evaluation \_\_\_\_\_ **Testing Performed was:**      **SCREENING**      **DIAGNOSTIC**

<b>Tests (mark all that apply)</b>	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) _____

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

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

<b>Recommendations / Referrals (please indicate date(s) of referral(s) and date(s) of appointment(s))</b>	<b>Date</b>
Early Intervention Services (EI) <span style="float: right; font-size: small;">(date of referral)</span>	
Division Of Specialized Care For Children (DSCC) <span style="float: right; font-size: small;">(date of referral)</span>	
Medical Referral (to whom?) <span style="float: right; font-size: small;">(date of appointment)</span>	
Amplification Evaluation <span style="float: right; font-size: small;">(date of appointment)</span>	
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

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