



# 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 \_\_\_\_\_

Screeener'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***

