DEPARTMENT OF HEALTH

NEWBORN HEARING SCREENING AUDIOLOGY FOLLOW-UP REPORT FORM

PATIENT INFORMATION

Child's Name (Last, First): Date of Birth: Gender at Birth: Female Male

Address, City, State:

Mother/Parent Name (Last, First): Phone:

Caregiver's Name/Relationship/Phone (if different): Language Used in Home:

Primary Care Physician: Primary Clinic Name, City:

If not MN birth, **include birth hospital or home birth city/state**:

TEST RESULTS

IMPORTANT: test both ears & do not delay complete audiological diagnosis due to middle ear fluid

Date of Service: Audiologist: Clinic Name, City:

ALL THAT APPLY	RIGHT EAR				LEFT EAR			
AABR (screening)	Pass	Refer	Inconclusive	Not Done	Pass	Refer	Inconclusive	Not Done
DPOAE	Pass	Refer	Inconclusive	Not Done	Pass	Refer	Inconclusive	Not Done
TEOAE	Pass	Refer	Inconclusive	Not Done	Pass	Refer	Inconclusive	Not Done
Tympanometry 226 Hz 1000 Hz	Peak	Rounded	No Peak	Lg. Volume	Peak	Rounded	No Peak	Lg. Volume
Acoustic Reflex (Ipsi)	Normal	Elevated	Absent		Normal	Elevated	Absent	

Screening or diagnostic results

	DIAGNOSIS	RIGHT EAR Degree	RIGHT EAR Type	LEFT EAR Degree	LEFT EAR Type
Click ABR		Normal	Normal	Normal	Normal
Toneburst ABR		Slight	Sensorineural	Slight	Sensorineural
Bone Conduction ABR		Mild	Perm. Conductive	Mild	Perm. Conductive
ASSR		Moderate	Transient Cond.	Moderate	Transient Cond.
Narrow Band Chirps		Mod. Severe	Mixed	Mod. Severe	Mixed
Headphones/insert		Severe	ANSD	Severe	ANSD
Non-ear specific VRA		Profound	Undetermined	Profound	Undetermined
Sedated testing					

REFERRALS AND APPOINTMENTS

CHECK ALL THAT APPLY IF KNOWN

Audiology	Appointment Date:	Amplification	Loaner Fit Date:
Otolaryngology	Appointment Date:	Genetic Evaluation	Appointment Date:
Help Me Grow	Date of Referral:	Ophthalmology	Appointment Date:
Parent Support	Date of Referral:	Other (specify):	

NOTES/APPOINTMENT CHANGE

FAX COMPLETED FORM AND COPY OF VISIT SUMMARY TO 651-215-6285

For more information, please contact health.newbornhearing@state.mn.us

REV 09/2025