ARIZONA 0-2 OAE REPORTING FORM

Child's First Name_____**Last Name**_____**Date of Birth**_____

Birth Hospital _____**Located in (State)**_____**Gender** □ **M** □ **F**

Mother's First Name_____ **Last Name** _____ **Mother's Date of Birth**_____

Name of Screener_____**Contact Info:**_____

Name of Screening Site _____

Street Address_____**City/State/Zip**_____

Screening being conducted at: (check all that apply)

☐ **Child care** ☐ **School** ☐ **Community event (health fair, etc.)** ☐ **Health Care Provider**

☐ **Individual screening event** ☐ **Other:** _____

Does the child have Pressure Equalization (PE) tubes in either ear?
□ **Yes** □ **No**

Visual Inspection **Date** (___/___/___)

☐ *Refer Right*

☐ *Refer Left* → Consult health care provider
Rescreen after medical clearance

Child's RIGHT Ear

☐ *Pass visual inspection*

1st OAE (___/___/___)

☐ *Can't test*
☐ ***Refer***
☐ *Pass*

2nd OAE (___/___/___)
(2 weeks if CNT, 4 weeks if Refer)

☐ *Can't test*
☐ ***Refer***
☐ *Pass*

☐ **Report and notify parents**

Child's LEFT Ear

☐ *Pass visual inspection*

1st OAE (___/___/___)

☐ *Can't test*
☐ ***Refer***
☐ *Pass*

2nd OAE (___/___/___)
(2 weeks if CNT, 4 weeks if Refer)

☐ *Can't test*
☐ ***Refer***
☐ *Pass*

☐ **Report and notify parents**

Schedule follow-up (___/___/___)

Middle Ear Consultation

(by health care provider)

If middle ear is clear, refer for an Audiological Evaluation by a pediatric audiologist.

If treatment is needed, a repeat OAE screen is recommended after treatment has been completed.

Refer to a pediatric audiologist if you cannot conduct rescreen after treatment.

Notes:_____
_____
_____
_____
_____
_____

REQUIRED REPORTING IF CONDUCTING SCREENING WITH CHILD FROM AGE BIRTH TO 2:
Infant means the same as in A.R.S. §36-694 : *" Infant" means a child who is twenty-nine days of age to two years of age.*
Within one week of screening, submit results to the Arizona Department of Health Services (ADHS).

Fax to: **602-364-1495** mail to: **Newborn Screening Program**
250 N. 17th Avenue
Phoenix, Arizona 85007

If questions or you need help with resources call ADHS at 800-548-8381

ADDITIONAL INFORMATION FOR HEALTH CARE PROVIDERS

If possible, try to obtain answers to these questions from the parent/guardian

Is this the first time a hearing screening has been performed on this child? No Yes-if yes:

Was child screened for hearing loss at birth? ☐ ☐ Unknown ☐ ☐ Not Screened ☐ ☐ Passed ☐ ☐ Referred

Any neonatal risk factors or complications? ☐ ☐ Unknown ☐ ☐ No ☐ Yes: _____

Any family history of early hearing loss? ☐ ☐ No ☐ ☐ Yes: _____

Is the parent/caregiver concerned about the child's: Hearing? ☐ No ☐ ☐ Yes: _____

Speech? ☐ No ☐ ☐ Yes: _____

Has the child experienced:

Head trauma? ☐☐ No ☐ Yes: _____

Recurrent ear infections? ☐☐ No ☐ Yes: _____

Meningitis? ☐ No ☐ Yes:_____

The Joint Committee on Infant Hearing recognizes that an optimal surveillance and screening program within the medical home would include the following:

- At each visit, consistent with the AAP periodicity schedule, infants should be monitored for auditory skills, middle-ear status, and developmental milestones (surveillance). Concerns elicited during surveillance should be followed by administration of a validated global screening tool. A validated global screening tool is administered to all infants at 9, 18, and 24 to 30 months or, if there is physician or parental concern about hearing or language, sooner
- If an infant does not pass the speech-language portion of the global screening in the medical home or if there is physician or caregiver concern about hearing or spoken-language development, the child should be referred immediately for further evaluation by an audiologist and a speech-language pathologist for a speech and language evaluation with validated tools.
- Once hearing loss is diagnosed in an infant, siblings who are at increased risk of having hearing loss should be referred for audiological evaluation.
- All infants with a risk indicator for hearing loss regardless of surveillance findings, should be referred for an audiological assessment at least once by 24 to 30 months of age. Children with risk indicators that are highly associated with delayed-onset hearing loss, such as having received ECMO or having CMV infection, should have more frequent audiological assessments. Risk Factors include:
  - o Caregiver concern regarding hearing, speech, language, or developmental delay.
  - o Family history of permanent childhood hearing loss.
  - o All infants with or without risk factors requiring neonatal intensive care for greater than 5 days, including any of the following: ECMO,* assisted ventilation, exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix). In addition, regardless of length of stay: hyperbilirubinemia requiring exchange transfusion.
  - o In utero infections, such as CMV, herpes, rubella, syphilis, and toxoplasmosis.
  - o Craniofacial anomalies, including those that involve the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies.
  - o Physical findings, such as white forelock, that are associated with a syndrome known to include a sensorineural or permanent conductive hearing loss.
  - o Syndromes associated with hearing loss or progressive or late-onset hearing loss,§ such as neurofibromatosis, osteopetrosis, and Usher syndrome; other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson.
  - o Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome.
  - o Culture-positive postnatal infections associated with sensorineural hearing loss,§ including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis.
  - o Head trauma, especially basal skull/temporal bone fracture§ that requires hospitalization.
  - o Chemotherapy.
- All infants for whom the family has significant concerns regarding hearing or communication should be promptly referred for an audiological and speech-language assessment.
- A careful assessment of middle-ear status (using pneumatic otoscopy and/or tympanometry) should be completed at all well-child visits, and children with persistent middle-ear effusion that last for 3 months or longer should be referred for otologic evaluation.