Arizona Early Hearing Detection and Intervention
Arizona Department of Health Services
Hearing Out-Patient Screening Form

Screener or Contact Name: ____
Screener or Contact Phone:____
Date Submitted:______________________
Facility Name: ____

FAX TO 602-364-1495 within one week of screening

- **Submit for all infants screened up to two years of age.**
- **Do not submit if previous testing shows normal hearing and child is being screened for otitis media.**
- **Submit diagnostic report form if diagnostic testing was completed**

Patient Last Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Patient First Name:	Birth Order (if multiple births): ☐ A ☐ B ☐ C ☐ D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Screen:	
Primary Care Physician:	**Right:** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail
Comments:	☐ **OAE** ☐ **ABR** ☐ **Behavioral**	
Patient Last Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Patient First Name:	Birth Order (if multiple births): ☐ A ☐ B ☐ C ☐ D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Screen:	
Primary Care Physician:	**Right:** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail
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Comments:	☐ **OAE** ☐ **ABR** ☐ **Behavioral**	

Fax to: 602-364-1495 Questions call 602-364-1409
Always start a new log sheet after faxing to ADHS