

HEARING SCREENING LOG SHEET

Infant Information Here (Printed label here)	Screen Date	R Ear Result	L Ear Result	Screener Initials	If REFER at discharge, schedule RESCREEN: Date and Location	Risk Factors for Hearing Loss	Parents told of Result	Result sent to PCP	Result sent to MDH
	1)				Date:	___ Family history of hearing loss ___ NICU stay > 5 days ___ In utero infections (CMV, etc) ___ Ototoxic Meds > 5 days ___ Craniofacial abnormalities ___ Syndrome: _____	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
	2)				Location:		No: <input type="checkbox"/>	No: <input type="checkbox"/>	No: <input type="checkbox"/>
	1)				Date:	___ Family history of hearing loss ___ NICU stay > 5 days ___ In utero infections (CMV, etc) ___ Ototoxic Meds > 5 days ___ Craniofacial abnormalities ___ Syndrome: _____	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
	2)				Location:		No: <input type="checkbox"/>	No: <input type="checkbox"/>	No: <input type="checkbox"/>
	1)				Date:	___ Family history of hearing loss ___ NICU stay > 5 days ___ In utero infections (CMV, etc) ___ Ototoxic Meds > 5 days ___ Craniofacial abnormalities ___ Syndrome: _____	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
	2)				Location:		No: <input type="checkbox"/>	No: <input type="checkbox"/>	No: <input type="checkbox"/>
	1)				Date:	___ Family history of hearing loss ___ NICU stay > 5 days ___ In utero infections (CMV, etc) ___ Ototoxic Meds > 5 days ___ Craniofacial abnormalities ___ Syndrome: _____	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
	2)				Location:		No: <input type="checkbox"/>	No: <input type="checkbox"/>	No: <input type="checkbox"/>
	1)				Date:	___ Family history of hearing loss ___ NICU stay > 5 days ___ In utero infections (CMV, etc) ___ Ototoxic Meds > 5 days ___ Craniofacial abnormalities ___ Syndrome: _____	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
	2)				Location:		No: <input type="checkbox"/>	No: <input type="checkbox"/>	No: <input type="checkbox"/>