Sample Physician Fax-Back Form

A child in your care Did Not Pass the Hearing Screening. As this is considered a critical value at XYZ Hospital, we must have confirmation that this information has been received by the child's primary care provider. Please fax a signed copy of this document back to us at XXX-XXX-XXXX

Attn: **Dr. Mary Mahoney** – **Fax Number:** XXX-XXX-XXXX

Location: Feel Good Clinic **Phone Numbe**r: XXX-XXX-XXXX
1234 Smith Rd. City WI, 55555

Child's Name: _____

Birth Date: _____ **Place of Birth:** _____

Parent/guardian's Name: _____

Primary Care Provider: _____

Organization/Clinic Name: _____

Address: _____

_____

Phone: _____

Hearing Evaluation Results: *(complete all that apply)*

☐ Inpatient Hearing Screen Completed - Date: _____

Location: _____

Right: ☐Pass ☐Refer ☐ ABR ☐ OAE
Left: ☐Pass ☐Refer ☐ ABR & OAE

☐ Outpatient Hearing Screen Scheduled - Date: _____

Location: _____
Phone: _____

Please assist us in making sure this family understands the importance of hearing screening follow-up by:
☐ reminding the family of the next appointment
☐ checking in with the family about the results of the follow-up appointment
☐ educating the family of the impact of not finding out if the child has a hearing loss

☐ A referral for a diagnostic audiology evaluation has been made. Location: _____

Appointment Date: _____ Phone Number: _____

_____

Fax was received on :

Signature: _____

Please Fax Back to the XYZ Hospital at XXX-XXX-XXXX!