Infant's Name: ______________________________ **DOB:** _______________

A **hearing screening** using ❑ Automated ABR or ❑ OAE was completed on ______________________________ for your infant. Test results indicated:

RIGHT EAR:

❑ Passed

❑ Did not pass and further testing is needed.

❑ Testing could not be completed and further testing is required.

LEFT EAR:

❑ Passed

❑ Did not pass and further testing is needed.

❑ Testing could not be completed and further testing is required.

❑ Please call ____________________ to schedule an appointment.

❑ An appointment has been scheduled for you at ________ ❑ a.m. / ❑ p.m.,

____

(DATE) (LOCATION)

Please take this card with you to your primary care physician and audiologist appointments.

For more information or assistance in locating follow-up services, please contact SoundBeginnings at

1-800-332-6262 * **www.soundbeginnings.org** * **Email: sbeginnings@kdheks.gov**