SoundBeginnings

KANSAS HEARING SCREEN FORM

Screening Facility: _____

Patient Name: _____

Date of Birth: _____

Mother's Name: _____

Primary Care Physician: _____

Date Hearing Screened: _____

Physiologic Equipment Used ____ **OAE** ____ **AABR**

Results of the hearing screen

Right Ear ___ **Normal** ____**Abnormal**
Left Ear ___ **Normal** ____**Abnormal**

Name of Screener: _____

***This child has been referred on for audiologic assessment to**

_____

On ____/_____/_____ ***at*** _____

Release of Information*: I authorize the release of records to KDHE SoundBeginnings Hearing Screening Program, Primary Care Physician, Pediatric Audiologist, Early Head Start, Parents As Teachers, Infant Toddler Early Intervention, and medical home provider for further treatment if required*

_____

Parent Signature **Date**

SOUNDBEGINNINGS Newborn Hearing Screening Program
Curtis State Office Building, 1000 SW Jackson St., Ste. 220, Topeka, KS 66612-1274
785-368-8376 | Fax 785-559-4240 | www.soundbeginnings.org

Please Fax this Form to 785-559-4240