State of Illinois
Illinois Department of Public Health

Early Hearing Detection and Intervention
Newborn Hearing Screening Report

Child's Name _____ Med. ID _____

Other names this infant may also be known as:

_____

Date of Birth _____ Sex: ❑ Male ❑ Female

Birth Hospital _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

_____
(City) (State) (ZIP) (County) (Phone)

Physician's **FULL** Name _____

Phone _____ FAX _____

Screener's Name _____

Address _____

Phone _____ Date Completed _____

Screening Technology Used: ❑ TEOAE ❑ DPOAE ❑ Automated ABR

Screening Results:

Right Ear Result	❑ **Pass**	❑ **Refer**
Left Ear Result	❑ **Pass**	❑ **Refer**

NOTES

Illinois Department of Public Health
Early Hearing Detection and Intervention
535 W. Jefferson St., 2nd floor
Springfield, IL 62761
217-782-3300

This form may be faxed to: 217-524-4201
OR
E-mailed to: ***dph.hearingreports@illinois.gov***