RI HAP RHODE ISLAND HEARING ASSESSMENT PROGRAM

SOUND BEGINNINGS FORM

INFANT DATA

Date of Birth ___ / ___ / ___ Gestational Age ___ Gender ___

Mother's Name _____

Baby's Name _____

Address _____

_____

Phone Number _____

Private Pediatrician _____

RISK FACTORS

☐ NONE | ☐ Skin Tag(s) | ☐ Preauricular Pit(s) | ☐ Cleft Palate | ☐ Cleft Lip

☐ Family History of Childhood Hearing Loss (*Please Specify*) _____

☐ Syndrome Associated with Hearing Loss (*Please Specify*) _____

☐ Birth Weight less than 1500 grams (3lbs, 5oz)

☐ Other (*Please Specify*) _____

_____

		OAE Left	OAE Right
SCREEN	DATE ___/___/___	☐ MISS ☐ CNT ☐ DNT	☐ MISS ☐ CNT ☐ DNT
	SCREENER INITIALS _____	*Result* _____	*Result* _____

RECOMMENDATION

(PASS NO RISK FACTORS) ☐ DISCHARGE	(FAILED INITIAL SCREEN) ☐ RESCREEN	(MISSED INITIAL SCREEN) ☐ OUTPATIENT INITIAL	(PASS HAS RISK FACTORS) ☐ VRA for MEDICAL MONITOR		(FAILED RETURN SCREENING) ☐ DIAGNOSTIC ABR
	PLEASE SCHEDULE BEFORE DISCHARGE DATE _____	PLEASE SCHEDULE BEFORE DISCHARGE DATE _____	RIHAP WILL CONTACT FAMILY		

Screener's Name _____ Date ___ /___ /___

RIHAP or Audiologist Signature _____ Date ___ /___ /___ Data Entry Stamp

PROGRESS NOTES

NOTE: ALL REMARKS MUST INCLUDE THE SIGNATURE OF PROVIDER, DATE AND TIME.

Date and Time	*Comments and Remarks*

AABR Results Attached Here