Rev 2/5/2020

UTAH DEPARTMENT OF HEALTH

Utah Newborn Hearing Screening & CCHD ***Weekly*** Reporting Form

Please print clearly and fill out all that apply

Midwife ______	Screener ______	Facility ______	Date ______

Baby Info	Mom Info	Initial Screen/ Rescreen ★Both Ears must be tested on Rescreen	RIGHT Ear	LEFT Ear	Baby's MD & CMV ★FILL OUT if 2 Refers or 1st Refer is after 14 days of age	**CCHD Screening Results
Baby Name: Baby DOB: Gender: Blood Spot Kit Number:	Mom's Name: Mom's DOB: Phone: Address:	Initial Date: ______ Rescreen Date: ______	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Name: Facility: CMV discussed: Yes ☐ No ☐ CMV ordered*: Yes ☐ No ☐	Date | Time | R Hand | Foot | Result 1st: P F RS 2nd: P F RS 3rd: P F (Pass, Fail, Rescreen) Not Screened Reason ______ Echo Date & Time ______ ______
Baby Name: Baby DOB: Gender: Blood Spot Kit Number:	Mom's Name: Mom's DOB: Phone: Address:	Initial Date: ______ Rescreen Date: ______	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Name: Facility: CMV discussed: Yes ☐ No ☐ CMV ordered*: Yes ☐ No ☐	Date | Time | R Hand | Foot | Result 1st: P F RS 2nd: P F RS 3rd: P F (Pass, Fail, Rescreen) Not Screened Reason ______ Echo Date & Time ______ ______
Baby Name: Baby DOB: Gender: Blood Spot Kit Number:	Mom's Name: Mom's DOB: Phone: Address:	Initial Date: ______ Rescreen Date: ______	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Pass ☐ Refer ☐ Pass ☐ Refer ☐	Name: Facility: CMV discussed: Yes ☐ No ☐ CMV ordered*: Yes ☐ No ☐	Date | Time | R Hand | Foot | Result 1st: P F RS 2nd: P F RS 3rd: P F (Pass, Fail, Rescreen) Not Screened Reason ______ Echo Date & Time ______ ______

Please submit results WEEKLY to ehdi@utah.gov or fax to 801-536-0492***UDATED Feb. 2020 NOTE CHANGES

*Use UDOH CMV & ABR Testing Order Form

**CCHD Screening is completed on RIGHT HAND and EITHER FOOT. Repeat Screening for newborn with a RE-SCREEN result in ONE HOUR. If the 3rd result is a RESCREEN, proceed to fail.