Utah Department of
Health & Human Services
Family Health

Newborn Hearing Screening & CCHD Results

Baby's Name: _____ **Date of Birth:** _____ **Sex**: _____
Hospital or location of baby's birth: _____

Screening location: _____ Phone: _____
Screener: _____ Email: _____

Hearing Screening Results: (Please remember to always screen both ears)

_____ **Initial Screening** _____ **Follow-up Screening**
Screening Technology: _____ OAE _____ AABR

Date of Screening: _____
Right Ear: _____ PASS _____ FAIL **Left Ear:** _____ PASS _____ FAIL

CMV testing lab patient was referred to: _____
Pediatric Audiologist / Clinic baby referred to: _____

CCHD Screening Results:

	Date	Time	R Hand	Foot	Result
1st					Pass Fail Rescreen
2nd					Pass Fail Rescreen
3rd					Pass Fail Rescreen

Not Screened Reason:
_____

Parent or Guardian Contact Information:

Name: _____ Phone: _____
Address: _____

Baby's Primary Care Provider:_____ Phone: _____

I understand that newborn hearing screening is required by law (Utah Code 26B-4-319 and R398-2), and must be reported to the Utah Department of Health and Human Services Early Hearing Detection and Intervention program. The information will be used to ensure that appropriate referral and or follow-up services, when necessary, are made available to my child. I understand that this information will not be shared with unauthorized individuals.

_____ _____
Parent / Guardian Signature Date

To the screening agency: Please complete this entire form and return copies to our office and to the birth hospital listed.
Fax: (801) 536-0492 **Email: EHDI@utah.gov**