NEWBORN HEARING SCREEN
PRIMARY CARE PROVIDER REFERRAL FAX

Baby's Name _____ Birth Facility _____

Address _____ City _____ State_____ Zip_____

Language English ☐ Spanish ☐ Other ☐ _____

Mother's Name _____ Phone _____ Alt. Phone _____

Dear Provider,

The baby listed above did not pass more than one hearing screen. Our records show that you have been chosen as the Primary Care Provider for this baby. It's important for this baby's speech and language skills to receive further testing so that he/she will be on track developmentally. Please help us facilitate this scheduled follow-up assessment listed below.

	Newborn hearing screen results		Comments
Pass	☐ Right	☐ Left	_____
Referred	☐ Right	☐ Left	_____
			_____

Audiology Evaluation / Treatment

Facility _____

Date _____ Time ____ : ____ AM ☐ PM ☐

Address _____

Phone _____ Alt .Phone _____

Thank you in advance for your support and attention to this baby's follow-up care.

Sincerely,

_____ _____

Hearing Screener *Contact Phone*

Rev. 5/2008