Louisiana Early Hearing Detection and Intervention Program

Audiology Follow-up Services Report (FSR)

Louisiana Department of Health and Hospitals | Office of Public Health
Early Hearing Detection and Intervention (**EHDI**) Program
www.ehdi.dhh.la.gov

Send report within **7 days** after contact

Child's Last Name (on birth certificate)	Child's First Name	Middle Initial	Child's DOB

Mother's Last Name	Mother's First Name	Mother's Maiden Name

Address	City	State	Zip	Phone Number ( )

Audiologist's Name: **Fax:**

Facility Name: **Phone:**

Hospital of Birth:

DATE **Today's Exam / Appointment:** _____

____ **Initial** Newborn Hearing Screening Test
____ **Follow-up** from **Failed** Newborn Screening
____ Monitoring for **"AT RISK"** →
____ Referral from Physician
____ Ongoing Monitoring of Confirmed Hearing Loss
____ Other Reason: _____

TYPE: ☐ **Screening** ☐ **Diagnostic**

☐ **Patient *Lost to Follow-up* for *YOUR* Facility**

DATE Reported _____

☐ Missed Appointment(s) #Missed _____
☐ Cannot contact Why? _____
☐ Physician Re-screened: **Who?** _____
☐ Moved out of state _____
☐ Other: _____

☐ **NO KNOWN RISK FACTORS**

Are there any RISK FACTORS for progressive or late onset hearing loss?
Check all that apply:

_____ Family history of permanent childhood hearing loss
_____ In utero/congenital infections (CMV, rubella, etc)
_____ Defects of head/ears/neck
_____ Elevated Bilirubin requiring exchange transfusion
_____ Ototoxic meds **> 5** days or combined with loop diuretic (ex. Lasix)
_____ Findings/Syndromes associated with hearing loss _____
_____ NICU **> 5** days
_____ Prolonged mechanical ventilation
_____ ECMO – Extracorporeal Membrane Oxygenation
_____ Postnatal infections (such as, bacterial meningitis)
_____ PPHN – Persistent Pulmonary Hypertension of the Newborn
_____ Head Trauma
_____ Recurrent or persistent otitis media with effusion for at least 3 months
_____ Neurodegenerative disorders
_____ Chemotherapy

RESULTS: *(check all that apply)* **Passed BOTH** ears ☐ Did **NOT** pass **LEFT** ☐ Did **NOT** pass **RIGHT** ☐

TESTING METHOD: ABR ☐ OAE ☐ Behavioral Audiometry ☐ Tympanometry ☐ Other _____

If child has a **confirmed or suspected** hearing loss, complete the following**:** *circle severity & type*

LEFT: **I** (21-40 dB) **II** (41-70 dB) **III** (71-90 dB) **IV** (> 90)
SNHL **Conductive** **Mixed** **Auditory Neuropathy**
Unknown type at this time

RIGHT: **I** (21-40 dB) **II** (41-70 dB) **III** (71-90 dB) **IV** (> 90)
SNHL **Conductive** **Mixed** **Auditory Neuropathy**
Unknown type at this time

Is hearing loss **confirmed and permanent**? ☐ Yes ☐ No (*Do not report conductive loss unless permanent, e.g. atresia*)

Primary Care Provider (PCP): _____ City: _____
Today's results reported to PCP: ☐ Yes ☐ No

Has child been fit with hearing aid? ☐ Yes LEFT / Date _____ ☐ Yes RIGHT / Date _____ ☐ Fitting in Progress
☐ Funding Unavailable ☐ Parent Refusal ☐ Not Recommended ☐ Other _____
Has child been fit with cochlear implant? ☐ LEFT / Activation Date _____ ☐ RIGHT / Activation Date _____

Referrals – *please indicate all that apply*

☐ PCP for Medical Follow-up
☐ ENT/OTO:
Facility _____ City: _____
☐ Audiological Evaluation
Facility Name: _____
Date of Scheduled Eval: _____
☐ Hearing Aid Eval – Facility Name _____
☐ Genetics – Facility Name: _____
☐ Ophthalmology – Facility Name _____
☐ Early Intervention:
☐ Early Steps ☐ Other/Program Name:_____
☐ Others – List: _____

Comments:

FAX OR MAIL REPORT TO:

DHH – OPH – Hearing, Speech & Vision
Attn: EHDI Data Clerk
P.O. Box 60630
New Orleans, LA 70160

FAX (504) 568 – 5854
Attn: EHDI Data Clerk

v. 01.01.13