



**Early Hearing Detection
and Intervention Program
(EHDI)**



INDIANA EHDI OUTPATIENT HEARING SCREENING RESULTS

Date of outpatient screening: _____ Location of outpatient screening: _____

Completed by: _____

Infant name: _____ DOB: _____

MRN#: _____ Birthing facility: _____

Mother's name: _____ Mother's phone #: _____

Reason for outpatient screen:

☐ Did not pass inpatient screen

☐ No inpatient screen

Reason for no inpatient screen: _____

Outpatient screen Results: Left ear: ☐ Pass ☐ Refer

Please circle: **OAE** **AABR**

Right ear: ☐ Pass ☐ Refer

Risk factor: ☐ Yes ☐ No

Specify: _____

If infant DID NOT PASS:

Audiology Referral Location _____

Primary Care Physician _____ PCP Phone _____

Date of audiology appointment, if scheduled _____

☐ This infant **NO SHOWED** the outpatient screen scheduled on: _____

Fax this form to the EHDI Program at 317-925-2888 immediately!

Questions? Please contact our office at 317-232-0888 or visit our website at www.hearing.in.gov.