



DIAGNOSTIC AUDIOLOGY EVALUATION (DAE)

State Form 53233 (R/10-07)

Indiana's Early Hearing Detection and Intervention (EHDI) Program

Instructions: Use this form to report to the Indiana State Department of Health:

- 1) Babies requiring follow-up from Universal Newborn Hearing Screening (UNHS).
- 2) Babies who did not receive UNHS, and any additional children diagnosed with permanent hearing loss.
- 3) Please fax completed form to 317-925-2888. Questions? Contact the EHDI Program at 855-875-5193

Patient Information:	Office ID
Child's Last Name	Child's First Name
Date of Birth (month, day, year)	Child's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Facility	UNHS Results <input type="checkbox"/> Pass <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown
Birth Mother's Last Name	Birth Mother's First Name
Mother's Current Address (Street, City, State, & Zip)	Mother's Phone Number
	Mother's Email
Primary Care Physician (PCP) Name	PCP Current Address (Street, City, State & Zip) & Phone Number

Date of Evaluation ___ / ___ / ___ Initial Report Follow-Up Report

Audiologist	Email
Clinic Name & Current Address (Street, City, State, & Zip)	Phone Number

Case History:

<input type="checkbox"/> Special Care/NICU (more than 5 days)	<input type="checkbox"/> Family History of Childhood Hearing Loss	<input type="checkbox"/> Parental Concern
<input type="checkbox"/> Hyperbilirubinemia requiring exchange transfusion	<input type="checkbox"/> Genetic Syndromes associated with hearing loss (_____)	
<input type="checkbox"/> Craniofacial Anomalies	<input type="checkbox"/> Bacterial Meningitis	<input type="checkbox"/> Ototoxic Medications
<input type="checkbox"/> In-utero Infection	<input type="checkbox"/> CMV	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Rubella	<input type="checkbox"/> Herpes	<input type="checkbox"/> Toxoplasmosis
<input type="checkbox"/> Other (_____)		

Methods of Evaluation:

<input type="checkbox"/> Click ABR	<input type="checkbox"/> Screening ABR	<input type="checkbox"/> TEOAE	<input type="checkbox"/> BOA	<input type="checkbox"/> High Frequency Tympanometry
<input type="checkbox"/> Toneburst ABR	<input type="checkbox"/> ASSR	<input type="checkbox"/> DPOAE	<input type="checkbox"/> VRA	<input type="checkbox"/> Tympanometry (220/226)
<input type="checkbox"/> Bone Conduction ABR	<input type="checkbox"/> CPA	<input type="checkbox"/> Sound Field		

Audiologic Results:

Left Ear Type	Left Ear Degree	Right Ear Type	Right Ear Degree
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal (0-20 dB HL)	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal (0-20 dB HL)
<input type="checkbox"/> Temp Conductive	<input type="checkbox"/> Mild (21-40 dB HL)	<input type="checkbox"/> Temp Conductive	<input type="checkbox"/> Mild (21-40 dB HL)
<input type="checkbox"/> Perm Conductive	<input type="checkbox"/> Moderate (41-55 dB HL)	<input type="checkbox"/> Perm Conductive	<input type="checkbox"/> Moderate (41-55 dB HL)
<input type="checkbox"/> Mixed	<input type="checkbox"/> Moderately-Severe (56-70 dB HL)	<input type="checkbox"/> Mixed	<input type="checkbox"/> Moderate-Severe (56-70 dB HL)
<input type="checkbox"/> Sensorineural	<input type="checkbox"/> Severe (71-90 dB HL)	<input type="checkbox"/> Sensorineural	<input type="checkbox"/> Severe (71-90 dB HL)
<input type="checkbox"/> Auditory Neuropathy	<input type="checkbox"/> Profound (91 + dB HL)	<input type="checkbox"/> Auditory Neuropathy	<input type="checkbox"/> Profound (91 + dB HL)
<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Undetermined

Comments:

Additional Recommendations/Resources:

<input type="checkbox"/> Medical Follow-up with PCP	<input type="checkbox"/> Enrolled in First Steps	<input type="checkbox"/> Referred to First Steps
<input type="checkbox"/> Medical Follow-up with ENT	<input type="checkbox"/> Hearing Aid(s)	<input type="checkbox"/> Cochlear Implant(s)
ENT Provider: _____ Phone #: _____	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Referral for Genetics	<input type="checkbox"/> Communication Assessment (Spoken/Visual)	
Genetics Provider: _____ Phone #: _____	<input type="checkbox"/> Family Resource Guide	
	<input type="checkbox"/> SKI*HI Parent Advisor/Family Education	
<input type="checkbox"/> Other EI Services _____		
<input type="checkbox"/> Referral for Vision Screening/Evaluation _____		
<input type="checkbox"/> Audiologic Monitoring: <input type="checkbox"/> in ___ months <input type="checkbox"/> in ___ weeks Scheduled Follow-up Date (month, day, year): _____		

Results Communicated to: PCP ENT Parent/Family First Steps GBYS Other _____