

**Early Hearing Detection and Intervention Direct Referral Form
for Diagnostic Audiology Evaluation**

Communicating Did Not Pass Results

Congratulations on the birth of your baby. We just finished screening your baby's hearing. Your baby did not pass two hearing screenings. This does not necessarily mean that your baby has a hearing loss, but without additional testing we can't be sure. Funding for follow-up testing can be found through private insurance, Medicaid, Children's with Special Healthcare Services (CSHCS), or private pay. If you would like to use Medicaid, private insurance, or pay for the services yourself, we will help you make the follow-up appointment before you leave the hospital. If you are interested in applying for CSHCS, we will assist you in getting the appropriate paperwork. If this form is being provided after hours or on the weekend, the hospital staff will be contacting you at home with the time and date of the appointment.

Northeast Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Advanced Hearing Care
1827 N Madison Ave Suite C
Anderson, IN 46011
Phone: (765) 608 3277
Fax: (765) 608-3278

ENT Associates
10021 Dupont Circle Ct.
Fort Wayne, IN 46825
Phone: (260) 426-8117
X1626
Fax: (260) 416-0347

Outreach Services for
Deaf and Hard of Hearing
Children
Indiana School for the Deaf
1200 E 42nd St
Indianapolis, IN 46205
Phone: (317) 920-6347
Toll Free (800) 724-9550
Fax: (317) 920-6350

Parkview Hospital
2200 Randallia
Fort Wayne, IN 46805
Phone: (260) 373-4527
Fax: (260) 373-2479

Ball State University
AC 104
Muncie, IN 47306
Phone: (765) 285-8160
Fax: (765) 285-5623

MCHA Hearing Solutions
442 W High St
Bryan, OH 43506
Phone: (419) 636-4517
Fax: (419) 636-6438

St John's Health System
2015 Jackson St
Anderson, IN 46016
Phone: (765) 646-8172
Fax: (765) 608-3909

Appointment: Scheduled Needs to be Scheduled Interpreter-Type Needed: _____

Date: _____ Time: _____

Newborn Information

Name: _____ Date of Birth: _____

Birth Facility: _____ Screening Facility: _____

Hearing Screening Date: _____

Hearing Screening Results: Right Pass Refer Left Pass Refer

Funding for follow-up: Medicaid CSHCS Self Pay Private Insurance _____

Parent/Guardian Contact Information

Name: _____ Language Spoken at Home: _____

Address: _____

Phone #: _____ Alternate Phone #: _____

Alternate Contact (Friend/Relative)

Name: _____ Phone #: _____

Primary Care Provider

Name: _____ Phone #: _____

Diagnosis: Suspected Hearing Loss **Diagnosis Code:** 389.9 **This order is valid for six (6) months from the date ordered.**

Physician Authorizing Diagnostic Audiology Evaluation As the Primary Care Provider, you must sign below and fax back to the facility selected above at least 7 days before the above scheduled appointment or it will be cancelled. Signature must be that of the physician. A copied signature is acceptable.

Physician Signature: _____

Date: _____