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

Fax within **7 days** after contact to: 504 – 568 – 5854

Child's Last Name (on birth certificate)	Child's First Name	Middle Name	Suffix	DOB
Mother's Last Name	Mother's First Name	Mother's Maiden Name	Phone #	Alternate Phone #
Address	City	State / Zip	Alternate Phone #	Email
Birth Hospital/Facility	Primary Care Physician (PCP)		PCP City	
Audiology Facility Name	Audiologist Name		Facility Phone	Facility Fax

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

☐ **No Risk Indicators Identified**

☐ Family History of Permanent Childhood Hearing Loss
☐ Neonatal Intensive Care **More than 5 Days**
☐ Extracorporeal Membrane Oxygenation (ECMO)
☐ Assisted Ventilation
☐ Ototoxic Medications: ___Aminoglycosides ___Loop Diuretics
☐ Hyperbilirubinemia Requiring Exchange Transfusion
☐ Congenital Infection (check all that apply):___CMV, ___Toxoplasmosis, ___HIV, ___Herpes, ___Syphilis, ___Zika, ___Other_____
☐ Craniofacial Anomalies Specify:_____
☐ Physical Findings/Syndrome Associated with Hearing Loss Specify:_____
☐ Culture Positive Postnatal Infection Specify:_____
☐ Neurodegenerative Disorders Specify:_____
☐ Head Trauma
☐ Recurrent or Persistent Otitis Media with Effusion for at Least 3 Months
☐ Chemotherapy Specify Drug: _____

DATE OF TODAY'S EXAM: _____ **REASON?:** *(Check one below)*

○ **INITIAL** Newborn Hearing Screening Test
○ Follow-up from **FAILED** Newborn Hospital Screening
○ Monitoring for "AT RISK"
○ Referral from Physician
○ Ongoing Monitoring of Confirmed HL
○ Other (specify):_____

Screening Results - Outpatient

☐ **OAE**	**Left**:	○ Passed	○ Did not pass	○ Could not test	**Right**:	○ Passed	○ Did not pass	○ Could not test
☐ **ABR**	**Left**:	○ Passed	○ Did not pass	○ Could not test	**Right**:	○ Passed	○ Did not pass	○ Could not test

Diagnostic Results - Outpatient

☐ **OAE**	**Left:**	○ Passed	○ Did not Pass	○ Could not Test	**Right**	○ Passed	○ Did not Pass	○ Could not Test
☐ **ABR**	**Left:**	○ Passed	○ Did not Pass	○ Could not Test	**Right**	○ Passed	○ Did not Pass	○ Could not Test
☐ **Behavioral**	**Soundfield:**	○ Abnormal	○ Within Normal Limits					
☐ **Tympanometry**	**Left:**	○ Passed	○ Did not Pass	○ Could not Test	**Right:**	○ Passed	○ Did not Pass	○ Could not Test
☐ **Other** _____	**Left:**	○ Passed	○ Did not Pass	○ Could not Test	**Right:**	○ Passed	○ Did not Pass	○ Could not Test

Is further testing needed to confirm or rule out PERMANENT hearing loss? ☐ YES ☐ NO

Today's Results Reported to PCP: ○ Yes ○ No

If child has a confirmed or suspected hearing loss, complete following to indicate severity & type:

Left Severity	Left Type	Right Severity	Right Type
○ Mild (21-40 dB) ○ Moderate (41-70 dB) ○ Severe (71- 90 dB) ○ Profound (>90 dB) ○ Undetermined	○ SNHL ○ Permanent Conductive ○ Transient Conductive ○ Mixed ○ Auditory Neuropathy ○ Undetermined	○ Mild (21-40 dB) ○ Moderate (41-70 dB) ○ Severe (71- 90 dB) ○ Profound (>90 dB) ○ Undetermined	○ SNHL ○ Permanent Conductive ○ Transient Conductive ○ Mixed ○ Auditory Neuropathy ○ Undetermined

Hearing loss is IDENTIFIED and PERMANENT: ☐ **No** ☐ **Yes** ***(do not report Transient Conductive as "permanent")***

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

Referrals: *please check all that apply*

☐ No Referrals Made
☐ PCP for Medical Follow-up
☐ ENT/OTO: Facility _____ City _____
☐ Audiological Evaluation:
Facility _____ Date_____
☐ Family-to-Family Support Organization _____
☐ Hearing Aid Evaluation
Facility Name_____
☐ Genetics: Facility Name_____
☐ Ophthalmology: Facility Name_____
☐ Early Intervention: ☐ Early Steps ☐ Other _____
☐ Other Referrals: List_____

Comments:

(Rev 10/2017)