NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

NEWBORN HEARING SCREENING REPORT AND REFERRAL FORM
EARLY HEARING DETECTION AND INTERVENTION PROGRAM
Children's Medical Services, Family Health Bureau
Birth Hospital/Birth Center is required to report hearing screen results for every birth.

Date Faxed / Mailed: _____ Name of Person Completing Form: _____

Phone Number of Person Completing Referral Form: _____

Medical Record #: _____ Birth Center/Hospital: _____

Hospital Contact Person: _____ Phone Number: _____

Baby's Last Name: _____ First Name: _____

Baby's Sex: _____ Male _____ Female Baby's Date of Birth: _____ Discharge Date: _____

Doctor Who Will Follow Baby Post Discharge:

Name: _____ Practice: _____

Address, City, State: _____

Phone Number: _____ Fax Number: _____

Parent Contact Information:

Mother's Name: _____ Mother's DOB: _____

Mother's Primary Language: _____ Mother's Email Address: _____

*Mailing Address: _____
***Please include apartment #, trailer space #, etc.**

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Message Phone Number: _____

Baby Has Hearing Loss Risk Factor(s): _____ Ototoxic Drugs _____ Prematurity _____ NICU
_____ Atresia/Microtia _____ Craniofacial Anomalies _____ Family History of Hearing Loss _____ Syndrome

Baby DOES NOT Have Any KNOWN Risk Factor(s) for Hearing Loss: _____

Hearing Screen Results:

Date(s) of Screen(s): _____ **Right Ear:** PASS / REFER / INCOMPLETE **Left Ear:** PASS / REFER / INCOMPLETE
_____ **Right Ear:** PASS / REFER / INCOMPLETE **Left Ear:** PASS / REFER / INCOMPLETE
_____ **Right Ear:** PASS / REFER / INCOMPLETE **Left Ear:** PASS / REFER / INCOMPLETE

Baby must pass screen in both ears during the same screen for it to be a pass.

Total # of Screens: _____ (Screen No More than 2 times unless 2nd screen was incomplete)

_____ **Discharged Without Screen Date**: _____ **Reason:** _____

_____ Transferred Date: _____ Transferred to: _____

Comments: _____

_____

Mother's signature for release: _____ Date: _____

All Fields on Form Must Be Completed. Send Completed Form to DOH Newborn Hearing Screening Program:
Securely Email to: newborn.hearing@doh.nm.govor **Fax** to: (505) 827-5995 or (505) 476-8896, or
Mail to: DOH/PHD/CMS Newborn Hearing Screening Program, 1190 S. St. Francis Drive, Santa Fe, NM 87505
Questions call: (505) 476-8817 or Toll Free at 1 (877) 890-4692 *Form version February 2022*