State of Illinois
Illinois Department of Public Health

Early Hearing Detection and Intervention (EHDI): Audiologist Follow-up Report

Child's Name: _____ Birth Hospital Med. ID _____

Other Names the Infant May be Known as: _____

Mother's Maiden Name or Mother's Last Name at Time of Infant's Birth: _____

Date of Birth _____ Sex: ☐ Male ☐ Female

Birth Hospital _____ City: _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

_____
(City) (State) (ZIP) (County) (Phone)

Infant's Primary Health Care Provider _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Audiologist Full Name
(please print) _____

Facility / Agency _____

Address _____
(City) (State) (ZIP)

Phone _____ FAX _____

Is there family history of permanent childhood hearing loss? ☐ Yes ☐ No

List any known risk factors:

Notes:

Submit BOTH PAGES of this form

Child's Name _____ **Testing Performed was:** ☐ **INPATIENT** ☐ **OUTPATIENT**

Date of this Evaluation _____ **Testing Performed was:** ☐ **SCREENING** ☐ **DIAGNOSTIC**

Tests (mark all that apply)	PER THE JOINT COMMITTEE ON INFANT HEARING: TESTING OF BOTH EARS SHOULD BE COMPLETED ON THE SAME DAY
☐ DPOAE	☐ Tympanometry 226 Hz
☐ TEOAE	☐ Tympanometry 1000 Hz
☐ Automated ABR (AABR)	☐ Acoustic Reflexes
☐ ABR - Click ☐ ABR Tone Burst	☐ Physical exam and/or review of medical records
☐ ASSR	☐ Other (Specify) _____

Diagnosis/ Type of Loss	**Right**	**Left**
Hearing within Normal Limits / PASS	☐	☐
Sensorineural Loss	☐	☐
Permanent Conductive Loss	☐	☐
Mixed Loss	☐	☐
Undetermined Type Loss / REFER comment: _____ _____	☐	☐

Degree of Loss	**Right**	**Left**
Not Applicable	☐	☐
Mild (26-40dB)	☐	☐
Moderate (41-55dB)	☐	☐
Moderately Severe (56-70dB)	☐	☐
Severe (71-90dB)	☐	☐
Profound (91+dB)	☐	☐
Sloping (describe)		

Recommendations / Referrals (please indicate date(s) of referral(s) and date(s) of appointment(s)		**Date**
Early Intervention Services (EI)	(date of referral)	
Division Of Specialized Care For Children (DSCC)	(date of referral)	
Medical Referral (to whom?)	(date of appointment)	
Amplification Evaluation	(date of appointment)	
Other (specify)		

This form is required to adequately document results. More specific evaluation information may be submitted in addition.

Submit BOTH PAGES of this form to:

Illinois Department of Public Health
Early Hearing Detection and Intervention
535 W. Jefferson St., 2nd floor
Springfield, IL 62761
217-782-4733

Reporting must be completed within 7 days of testing.
This form may be faxed to: **217-557-5324** OR E-mailed to:
dph.hearingreports@illinois.gov