Birth Facility Contacts

Birth Facility Name: ______________________

Facility City, State: ______________________

This form completed by: ______________________ **Date Completed:** ____________

Please fill out the contact information for all stakeholders involved in your newborn hearing screening program.

Provider Role:	Person's Name	Phone Number	Email Address
Screening Program Coordinator			
Nurse Manager for the newborn hearing screening program			
Outpatient Screening Coordinator			
Primary contact for the newborn hearing screening program			
Secondary contact for the newborn hearing screening program			
Staff audiologist who performs screening or inpatient diagnostic testing in the nursery			
Consulting audiologist for the newborn hearing screening program			
Women and Infants (WIS) Director			
Director Obstetrics			
Director Postpartum			
Director Neonatal Intensive Care Unit (NICU)			
Perinatal Network Administrator			
Chief Nursing Officer			
BioMed Liaison			
IT Liaison			
Clinical Educator			
Director of Pediatrics			
Other			