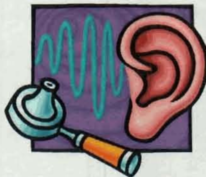
Hearing Screening Follow-up

Parent Infant Program
Fax: 801-629-4896
Attn: ***Lois Ann Ward***
801-629-4700



Castleview Hospital
Fax: 435-637-9513
Attn: ***Julie Sprague***
435-637-4800 x 3159

This form MUST BE SIGNED by parent BEFORE faxing.

Information to be completed by screener at time of scheduling for Out Patient Rescreen

Family Information

Mother's Name: ______________________

Language spoken: ______________________

Infant's DOB:________ Gender: **M** __ **F** __

Birth Record # ______________________

Address: ______________________

____

Phone: ______________

Child's Physician: ______________________

Audiologist: ______________________

***Relative/Friend not living with family**

Name: ______________________

Phone: ______________________

**Will be at a different (temporary) address during recovery* ___*Yes* ___*No* *Phone#* __________

Hearing Consultant

Name: ______________________

Phone: ______________

Date of 1st Contact: ________

Notes:

Date of 2nd Contact: ________

Notes:

Date of Inpatient Screen	Results	Notes	Date of Out Patient Rescreen(s)	Results	Notes
*1.	R: L:			R: L:	
2.	R: L:			R: L:	

****I give permission for this information to be released to the Parent Infant Program so that a hearing consultant may contact me about the hearing testing:***

Name: (print)______________________ Signature: ______________________

Relationship to Infant: ______________ Date: ______________________