Louisiana Early Hearing Detection and Intervention Program

**Audiology Follow-up Services Report (FSR)**
Louisiana Department of Health | Office of Public Health
Early Hearing Detection and Intervention (**EHDI**) Program
www.ehdi.dhh.la.gov

Fax within **7 days** to:
504 – 568 – 5854
Or scan to LAEHDI@la.gov

| 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 FACTORS for delayed-onset or progressive hearing loss?** *Check all that apply*

- ☐ **No Risk Factors Identified**
- ☐ Family History of Permanent Childhood Hearing Loss
- ☐ Neonatal Intensive Care More than 5 Days
- ☐ Extracorporeal Membrane Oxygenation (ECMO)
- ☐ Aminoglycoside Antibiotics More than 5 Days
- ☐ Hyperbilirubinemia Requiring Exchange Transfusion
- ☐ Congenital Infection:___CMV, ___Toxoplasmosis, ___HIV, ___Herpes, ___Syphilis, ___Rubella, ___Zika, ___Other (specify):_____
- ☐ Birth Conditions or Findings/Syndrome Associated with Hearing Loss: ___Microtia/Atresia of Ear, ___Ear Dysplasia, ___Cleft Lip/Palate, ___White Forelock, ___Microphthalmia, ___Microcephaly, ___Hydrocephalus, ___Temporal Bone Abnormalities, ___Other (specify): _____
- ☐ Culture Positive Postnatal Infection (specify):_____
- ☐ Perinatal Asphyxia or Hypoxic Ischemic Encephalopathy
- ☐ Head Trauma
- ☐ Chemotherapy (specify drug):_____
- ☐ Caregiver Concern

**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 |
|---|---|---|---|
| ○ Slight (16-25 dB) | ○ SNHL | ○ Slight (16-25 dB) | ○ SNHL |
| ○ Mild (26-40 dB) | ○ Permanent Conductive | ○ Mild (26-40 dB) | ○ Permanent Conductive |
| ○ Moderate (41-55 dB) | ○ Transient Conductive | ○ Moderate (41-55 dB) | ○ Transient Conductive |
| ○ Moderately Severe (56-70 dB) | ○ Mixed | ○ Moderately Severe (56-70 dB) | ○ Mixed |
| ○ Severe (71- 90 dB) | ○ Auditory Neuropathy | ○ Severe (71- 90 dB) | ○ Auditory Neuropathy |
| ○ Profound (>90 dB) | ○ Undetermined | ○ Profound (>90 dB) | ○ Undetermined |
| ○ Undetermined | | ○ 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 08/2020)*