



Hearing Screening Reporting Form

Organization: _____

Screener or Contact Name: _____

Screener or Contact Phone: _____

Date Submitted: _____

**Fax to: 602-364-1495 or Email to: hearing@azdhs.gov
or Mail to: Arizona Department of Health Services
Newborn Hearing Screening Follow Up
250 N. 17th Ave, 1st Floor
Phoenix AZ 85007**

Submit for all infants screened up to two years of age within ONE WEEK of screening.

Baby First Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Baby Last Name:	Birth Order: (if multiple birth) <input type="checkbox"/> A <input type="checkbox"/> B	
Mother First Name:	Mother's Date of Birth:	
Mother Last Name:	Type of Screening: <input type="checkbox"/> OAE <input type="checkbox"/> AABR	Date of Screening:
Primary Care Physician:	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Could not test	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Could not test
Name of Birth Facility or Midwife	<input type="checkbox"/> Refused: (Family interested in more information)	<input type="checkbox"/> Refused: (Do not contact family)
<input type="checkbox"/> Education was provided to family		
Comments:		

Arizona Revised Statute 36-694 mandates the reporting of all hearing screening for both newborns and infants (up to two years of age) to the Office of Newborn Screening. As prescribed by A.A.C. R9-13-207(E), all screening and diagnostic hearing evaluations shall be submitted within one week following the hearing test, even if the results are normal. If you have any further question please contact 602-364-1409