



AUDIOLOGY REPORTING FORM

Important: Enter hearing screening results in the Electronic Vital Records and Screening System (EVRSS) whenever possible. Providers without EVRSS access can submit this form by email or fax.

Submission Information

Email: dohnewbornscreening@state.sd.us

Fax: 866-579-8246, Attn: Newborn Hearing Program

Submit supporting records: Include waveform tracings and the clinical audiology report when reporting diagnostic results.

How to Use This Form

- Complete only the sections that apply to the reason for reporting.
- Use the same names, dates, addresses, and other demographic information shown in the child's medical or vital records.
- Select every option that applies. Write additional information in the comments fields.
- Do not use color or highlighting as the only way to communicate information.
- Keep a copy in the child's clinical record and send the completed form using the submission information in this document.

Reason for Reporting

Select all that apply.

- ☐ Screening
- ☐ Diagnostic assessment
- ☐ Refusal
- ☐ Deceased
- ☐ Moved out of state
- ☐ Transferred to another facility
- ☐ Risk factor
- ☐ No show
- ☐ Other: _____

Program Timing Goals

- Complete the initial hearing screening and any required rescreening before one month of age.
- Complete diagnostic testing by three months of age.
- Refer eligible children to early intervention services as soon as possible after identification.
- Follow applicable [South Dakota requirements and current clinical best practices](#).



1. Patient, Guardian, and Provider Information

Child Information

This table collects the child's identifying information.

First name	
Middle name	
Last name	
Date of birth (MM/DD/YYYY)	

Mother or Legal Guardian Information

This table collects contact information for the child's mother or legal guardian.

First name	
Middle name	
Last name	
Relationship to child	
Residence address	
Residence address City, state, ZIP code	
Mailing address, if different	
Mailing address City, state, ZIP code	
Phone number	
Email address	
Language used	

Other Caregiver, if Different

Complete this table only when another caregiver should be listed.

Caregiver name	
Relationship to child	
Phone number	
Email address	



Primary Care Provider

This table identifies the child's primary care provider.

Provider name	
Facility	
City and state	
Phone number	

2. Hearing Screening Results

Important: Rescreen both ears even when only one ear did not pass the initial screening. When the initial screening used automated auditory brainstem response, use automated auditory brainstem response for the rescreen.

Please complete this section if you are reporting a newborn hearing screening or subsequent follow-up screening.

Screening type	☐ Initial screening ☐ Follow-up screening
Screening setting	☐ Inpatient ☐ Outpatient
Screening date	
Screening time	
Location or facility	☐ Birthing hospital, inpatient ☐ Non-birthing facility ☐ Birthing hospital, outpatient ☐ Home
Screening method (if initial screen refers to AABR, rescreen should be AABR)	☐ Otoacoustic emissions (OAE) ☐ Automated auditory brainstem response (AABR) ☐ Other: _____
Was the screening completed?	☒ Yes ☐ No
If no, reason not completed	
Right ear result	☐ Pass ☐ Refer ☐ Not tested
Left ear result	☐ Pass ☐ Refer ☐ Not tested
Return for rescreen	☐ Yes ☐ No
Results reported to South Dakota Department of Health	☒ Yes ☐ No Date: _____
Results sent to primary care provider	☒ Yes ☐ No Date: _____



Next Steps After a Result Other Than Pass

Complete this table when either ear does not pass or when additional testing is needed.

Diagnostic appointment scheduled with pediatric audiologist	☒ Yes ☐ No
Appointment date	
Pediatric audiologist or clinic	
Comments	

3. Diagnostic Hearing Assessment Results

This table identifies the diagnostic assessment date and provider.

Assessment date	
Audiologist or clinic	

Reason for Assessment

Select all that apply.

- ☐ Referred newborn hearing screening
- ☐ Risk factor(s)
- ☐ Provider recommendation
- ☐ Parent or caregiver concern
- ☐ Other: _____

Risk Factors

Select all that apply. These items follow the terminology used in the source draft and Joint Committee on Infant Hearing resources.

- ☐ In utero infection, such as cytomegalovirus, syphilis, herpes, rubella, toxoplasmosis, or Zika
- ☐ Neonatal intensive care unit stay of more than five days
- ☐ Ototoxic medication, including aminoglycosides
- ☐ Hyperbilirubinemia requiring exchange transfusion
- ☐ Extracorporeal membrane oxygenation
- ☐ Asphyxia or hypoxic ischemic encephalopathy
- ☐ Family history of permanent childhood hearing loss
- ☐ Craniofacial abnormality, including microtia or atresia
- ☐ Syndrome associated with atypical hearing
- ☐ Other: _____



Diagnostic Protocol

Select all that apply.

- ☐ Otoscopic examination
- ☐ Tympanometry at 1000 Hz
- ☐ Tympanometry at 226 Hz
- ☐ Distortion product otoacoustic emissions
- ☐ Transient evoked otoacoustic emissions
- ☐ Auditory brainstem response using chirps
- ☐ Auditory brainstem response using clicks
- ☐ Auditory brainstem response using tone bursts
- ☐ Bone-conduction auditory brainstem response

Degree of Hearing Loss

Select one degree for each ear based on the completed diagnostic assessment.

Right ear	☐ Normal ☐ Slight ☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe ☐ Profound
Left ear	☐ Normal ☐ Slight ☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe ☐ Profound

Hearing loss ranges

Degree of hearing loss	Hearing loss range (dB HL)
Normal	-10 to 15
Slight	16 to 25
Mild	26 to 40
Moderate	41 to 55
Moderately severe	56 to 70
Severe	71 to 90
Profound	91 or greater

American Speech-Language-Hearing Association.

Type of Hearing Loss

Select one or more types for each ear, as appropriate.

Right ear	☐ Sensory or cochlear ☐ Neural or auditory neuropathy ☐ Conductive, temporary ☐ Conductive, permanent ☐ Mixed ☐ Unknown
Left ear	☐ Sensory or cochlear ☐ Neural or auditory neuropathy ☐ Conductive, temporary ☐ Conductive, permanent ☐ Mixed ☐ Unknown



Conductive hearing loss: Conductive hearing loss can result from fluid in the middle ear, otitis media, poor Eustachian tube function, a perforation in the eardrum or tympanic membrane, cerumen, external otitis, an object in the ear canal, or structural differences involving the outer ear, ear canal, or middle ear.

Use this field for interpretation, limitations, or other clinical information.

Clinical comments	
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Important: Submit waveform tracings and the complete clinical audiology report with this section above.

4. Recommendations and Referrals

Select all recommendations that apply.

- ☐ Continue monitoring
- ☐ Amplification
- ☐ Retest because testing was incomplete
- ☐ Retest because results were inconclusive
- ☐ Other: _____

Complete this table when a retest is recommended.

Retest date	
Retest audiologist or clinic	

Document when results were shared.



Results reported to South Dakota Department of Health	☒ Yes ☐ No Date: _____
Results sent to primary care provider	☒ Yes ☐ No Date: _____

Referrals Made

Select all that apply and enter the referral date.

- ☐ Otolaryngologist or ear, nose, and throat specialist
- ☐ Genetics
- ☐ Ophthalmology
- ☐ South Dakota Services for the Deaf
- ☐ South Dakota Hands & Voices
- ☐ South Dakota DeafBlind Program
- ☐ South Dakota Department of Education Birth to Three Early Intervention Program
- ☐ Other: _____

Record referral dates and any needed follow-up information.

Referral date or dates	
Referral notes	

For a Birth to Three referral, contact the service coordinator who serves the county where the family lives. [Find South Dakota Birth to Three referral information.](#)

Resources

- [Early Hearing Detection and Intervention risk factor resources](#)
- [American Speech-Language-Hearing Association hearing loss reference](#)
- [American Academy of Pediatrics Early Hearing Detection and Intervention resources](#)
- [EHDI-PALS pediatric audiology facility directory](#)



5. Authorization to Release Information to Birth to Three

Privacy notice: Clinical records are confidential. Information cannot be disclosed without authorization from the client or the client's authorized representative, except as permitted or required by law.

This table identifies the child and the person providing authorization.

Child's first name	
Child's last name	
Date of birth	
Parent or guardian full name	
Relationship to child	

I authorize the South Dakota Department of Education Birth to Three Early Intervention Program to release the information selected below about my child to the South Dakota Department of Health.

Select all that apply.

- ☐ Release of **Eligibility** for Early Intervention Services
- ☐ Release of **Enrollment** for Early Intervention Services

The parent or guardian must sign and date this authorization.

Parent or guardian signature	
Date signed	

For Office Use Only

Fax completed authorization to: 866-579-8246, Attn: Newborn Hearing Program Coordinator

Birth to Three staff complete this table before returning the form.

Early intervention eligibility	☐ Eligible ☐ Not eligible
Early intervention enrollment	☐ Enrolled ☐ Not enrolled
Date of determination, if applicable	
South Dakota Birth to Three director or authorized representative	
Date signed	



6. Authorization to Release Information to South Dakota Services for the Deaf

Privacy notice: Clinical records are confidential. Information cannot be disclosed without authorization from the client or the client's authorized representative, except as permitted or required by law.

This table identifies the child and the person providing authorization.

Child's first name	
Child's last name	
Date of birth	
Parent or guardian full name	
Relationship to child	

I authorize the diagnostic audiologist to release the following information about my child to South Dakota Services for the Deaf:

- ☐ Child's full name
- ☐ Parent or guardian full name
- ☐ Address and phone number
- ☐ Date of birth
- ☐ Diagnostic hearing test results
- ☐ Future diagnostic hearing test results

The parent or guardian must sign and date this authorization.

Parent or guardian signature	
Date signed	

Submission Reminder

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