SOUTH DAKOTA DEPARTMENT OF HEALTH

Audiology Reporting Form

Hearing screens should be entered into EVRSS when possible. Providers without EVRSS access may email this form to dohnewbornscreening@state.sd.us or FAX to 866-579-8246 - Attn: Newborn Hearing Program.

Child's First Name: _____ Child's Last Name: _____ DOB: _____
Parent/Guardian Name (full name): _____
Mailing Address: _____ City: _____
Zip code: _____ State: _____ Phone Number: _____
Primary Care Provider: _____ Provider's Clinic: _____

Screening Results Initial Screening ☐ Follow-up Screening ☐
Inpatient ☐ Outpatient ☐

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

Date and Time of Screening: _____
Screening Method: ☐aOAE ☐aABR
Right Ear: ☐Pass ☐Refer Left Ear: ☐Pass ☐Refer
Diagnostic Appointment Made: ☐Yes ☐No Date: _____
Audiologist: _____

Diagnostic Hearing Assessment Check if completed via Tele-Audiology☐
Date of Assessment: _____ Audiologist: _____

Degree of Hearing Loss

Right Ear	Left Ear
☐ Normal	☐ Normal
☐ Slight	☐ Slight
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Mod. Severe	☐ Mod. Severe
☐ Severe	☐ Severe
☐ Profound	☐ Profound

Type of Hearing Loss

Right Ear	Left Ear
☐ Sensory (cochlear)	☐ Sensory (cochlear)
☐ Neural (AN)	☐ Neural (AN)
☐ Conductive (temporary)	☐ Conductive (temporary)
☐ Conductive (permanent)	☐ Conductive (permanent)
☐ Mixed	☐ Mixed
☐ Unknown	☐ Unknown

Comments: _____

Recommendations
☐ Continue monitoring hearing
☐ Amplification
☐ Retest Retest date: _____

Referrals
☐ Report to PCP
☐ Otolaryngologist/ENT
☐ Genetics
☐ Ophthalmology
☐ SD Services for the Deaf
☐ Birth to Three

Contact the Service Coordinator who serves the county where the family resides. Link to Service Coordinator map: https://doe.sd.gov/birthto3/documents/B3-map-0722.pdf

Norms for Pediatric Hearing Loss

Normal (-10 to 15 dB HL)
Slight (16 to 25 dB HL)
Mild (26 to 40 dB HL)
Moderate (41 to 55 dB HL)
Mod. Severe (56 to 70 dB HL)
Severe (71 to 90 dB HL)
Profound (91+ dB HL)

Please continue onto the next page:
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Authorization to Release Information

By law, all clinical records are confidential. Information cannot be disclosed without the consent of the client or the client's representative.

Child's First Name: _____ Child's Last Name: _____ DOB: _____

Parent/Guardian Name (full name): _____

Relationship to Child: _____

I authorize the Birth-to-Three early intervention program within the South Dakota Department of Education to Release the following information about my child to the South Dakota Department of Health.

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

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

Parent/Guardian Signature: _____ Date: _____

For office use only.

FAX completed Authorization to Release Information to: (866) 579-8246
Attn: Newborn Hearing Program Coordinator

The child listed above is ☐**eligible** ☐**not** eligible to receive early intervention services.
The child listed above ☐**has** ☐**has not** been enrolled in early intervention services.

Date of determination (if applicable): _____
South Dakota Birth to Three Director: _____ Date: _____

Authorization to Release Information

By law, all clinical records are confidential. Information cannot be disclosed without the consent of the client or the client's representative.

Child's First Name: _____ Child's Last Name: _____ DOB: _____
Parent/Guardian Name (full name): _____
Relationship to Child: _____

I authorize the diagnostic audiologist to release the following information about my child to the South Dakota Services for the Deaf (SDSD).

☐ Child's full name, Parent/Guardian full name, address, phone number, Date of Birth (DOB), Diagnostic Hearing Test Results, and future diagnostic test results.

Parent/Guardian Signature: _____ Date: _____

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