Midwife Name: Month of Report:

			HEARING SCREENING DATA				CCHD SCREENING DATA	
Baby's Name (Last, First)	DOB (m/d/y)	Mother's Name (Maiden, First)	Screen Date	Left Ear Result	Right Ear Result	Follow Up Info *	Result	Comments **
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	
				Pass Refer	Pass Refer		Pass Fail Not Screened	

Click or circle one **Click or circle one**

MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

FAX to 406-449-0030

Thank You!!

MONTANA Newborn Screening

* **Hearing Screening Follow Up examples**: follow up appt date, 2nd screening date and results, referral made to PCP (list PCP), refused, etc

** **CCHD Comments**: If result is 'Not Screened', please state why. If result is 'Fail', please explain where baby was referred.