Indiana State Department of Health
Early Hearing Detection and Intervention Program

Outpatient Screen (or Re-Screen) Report

Birthing Hospital:____

Infant Name:____
First Middle Last

Medical Record Number (MRN):____________________________ DOB:____________________

Mother Name:____
First Middle Last

PCP Name:__________________________________ PCP Phone #:_______________________

Date of Initial Screen:_________________________

Date of Outpatient Screen:_____________________

Outpatient Screen Results:

Right Ear: Pass Refer

Left Ear: Pass Refer

Risk Factor: Yes No Specify:_________________________

If infant did not pass: Diagnostic test scheduled? Yes No

Location of diagnostic test:_______________________________________

Date of diagnostic test:____

☐ **This infant did not return for the scheduled outpatient re-screen.**

Return this form to the ISDH EHDI Program at: EHDI – Raney Hall
1200 E. 42nd St.
Indianapolis, IN 46205
Fax: 317-925-2888