Department of Health and Human Services
Maine Center for Disease Control and Prevention
Children with Special Health Needs
Maine Newborn Hearing Program
286 Water Street
Augusta, Maine 04333-0011
Tel.: (207) 287-5357; Fax: (207) 287-4743
TTY Users: Dial 711 (Maine Relay)

Hearing Screen Referral

Fax to Maine Newborn Hearing Program (MNHP) and Child's Primary Care Provider
MNHP Phone (207) 287-8427 MNHP Fax (207) 287- 4743

Child's Information

Name:_____Date of Birth (MM/DD/YYYY): ___/___/_____

Birth Facility _____ Screen Facility (If different) _____

Hearing Screen Date (MM/DD/YYYY): ___/___/_____ (Only enter information on most RECENT screen)

Result (circle for each ear) **Right Ear:** Pass Refer N/A **Left Ear:** Pass Refer N/A

Hearing Risk Factor(s): _____ (if known)

Parent/ Guardian Contact Information

Name: _____

Address: _____

Phone #: (_____)_____ Alternate #:(_____)_____

Please circle phone type: (mobile) (land line) (mobile) (land line)

****Alternate Contact (Friend/ Relative)****

Name: _____ _____(*Relation to child*)_____

Phone #: (_____)_____ Alternate #: (_____)_____

Follow-up Information (please check all applicable boxes)

☐ **Out Patient re-screening (returning to hospital) scheduled:**
Location _____ Phone #: (_____)_____
Date & Time _____

☐ **Audiologic Diagnostic Evaluation (audiology appointment) scheduled:**
Location _____ Phone #: (_____)_____
Date & Time _____

☐ **Hearing screening results provided to primary care provider in writing**
PCP Name:_____Phone #: (_____)_____

☐ **Refusal for follow-up screening/audiological assessment**
(Complete refusal form and fax both referral and refusal forms to MNHP and Primary Care Provider).