SoundBeginnings

Newborn Hearing Screening Program

Patient Name: _____ Patient Date of Birth: _____

Mother's Name: _____ Phone Number: _____

Facility Name: _____ Physician /Midwife: _____

I, _____ (Parent/Legal Guardian) of _____(child's name),

☐ **CONSENT** ☐ **DECLINE** to have my child's hearing screened. I have read the "SoundBeginnings Kansas Newborn Hearing Screening Program" brochure, understand the importance of having my baby's hearing screened, and have been given a list of facilities that provide hearing screens (if applicable).

By declining the hearing screen, I release _____ (Hospital/Midwife/Physician/ Facility) of any liability by refusing the hearing screen. I accept full responsibility. **Contact your child's physician if you decide to have your baby's hearing tested at a future date.*

Hearing Screening

Equipment Used: OAE **Date Screened:** _____

Results of Initial Hearing Screen

Right Ear ☐ Pass ☐ Did Not Pass

Left Ear ☐ Pass ☐ Did Not Pass

Results of Hearing Rescreen **Date Rescreened:** _____

Right Ear ☐ Pass ☐ Did Not Pass

Left Ear ☐ Pass ☐ Did Not Pass

Referral for Screening/Rescreening/Diagnostic Evaluation

Date of Referral: _____ Facility Referred To: _____

This child has been referred for a ☐ **Screening** ☐ **Rescreening** ☐ **Diagnostic Evaluation**

Release of Information: I consent to release hearing screen results to the Physician, Midwife, Audiologist, Screening Facility, or Program for the purpose of screening and/or treatment (if required).

Parent Signature: _____ **Date:** _____

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