

Beverly Hospital Audiology Department
Infant Hearing Screen/ History

Name of Infant: _____
Address: _____
Telephone #: _____
Date of Birth: _____
Parent/ Guardian Name: _____

General Information:

Primary Care Physician: _____
Who referred the patient for hearing screening?

Birth History:

Place of Birth: Beverly Hospital Birth Center

Risk Factors;

- Congenital Infection (TORCH)
- Craniofacial abnormalities
- Birth Weight
- Hyperbilirubinemia requiring transfusion
- Ototoxic medication
- Bacterial meningitis
- APGAR low
- Asphyxia
- Prolonged mechanical ventilation (10 days or more)
- Stigmata or syndrome
- Other

Check the following that may apply:

- Hearing screening performed at birth.
 Yes No
- Hearing screening passed at birth.
- Hearing screening refer at birth right left both

Other comments:

Filled out by: _____
Date: _____