Birth to Three\Early Hearing Detection & Intervention (EHDI) Fax-Back Form

Directions: We are asking B23 Programs to please **fax** this form for each new child with hearing loss that is less than 3-years-old to: the Connecticut Department of Public Health, EHDI Program at (860) 509-8132. No Coversheet needed. This information will help DPH EHDI with the early detection of hearing loss, the tracking of infants and young children who are deaf or hard of hearing, and the initiation of effective intervention systems. Many of the previously submitted forms have provided us with new information and helped the EHDI program to improve our tracking and outreach efforts. Thank you!

Child's Last Name First Name DOB

Parent\Responsible Name Parent\Responsible City & State

Birth Hospital (If born out of state please provide: City & State)

Primary Health Care Provider

Date of Diagnostic Evaluation (E.g. 07/04/2014) Location of Evaluation (E.g. CCMC, Yale, etc.)

Birth to Three Program

_____\ _____\ _____

Date child was first **referred** to B23 (if known) Date child was first found **eligible** for B23 Date child was **enrolled** in B23

Please complete information below or attach copy of audiological report:

HEARING LOSS TYPE:	**Left Ear**	**Right Ear**
Sensorineural	☐	☐
Conductive	☐	☐
Mixed	☐	☐
Undetermined Type Hearing Loss	☐	☐

HEARING LEVEL:		
Hearing within Normal Limits	☐	☐
Slight (16 to 25 dB HL)	☐	☐
Mild (26 to 40 dB HL)	☐	☐
Moderate (41 to 55 dB HL)	☐	☐
Moderately severe (56 to 70 dB HL)	☐	☐
Severe (71-90 dB HL)	☐	☐
Profound (91+ dB HL)	☐	☐

Additional Information (if known):

Hearing Aid Candidate? Yes ☐ No ☐ Not Determined ☐ Date of amplification_____

Cochlear Implant Candidate? Yes ☐ No ☐ Not Determined ☐ Date of implant_____

Risk Factors for Hearing Loss (check all that apply):

☐ Caregiver concern	☐ Cytomegalovirus (CMV)	☐ Culture positive postnatal infection
☐ Family history	☐ Syndrome associated with hearing loss	☐ Head trauma
☐ NICU >5 days	☐ Neurodegenerative disorder	☐ Chemotherapy

Additional information/recommendations/comments: _____

For CT Birth to Three Providers, please indicate the date Permission to Release Information Form 3-3 was signed by parent to release this information _____
Date

09-2014