CT DPH NEWBORN HEARING SCREENING\cCMV REPORTING FORM

This form is for Birth Hospitals, Midwife Facilities, PCP offices, and Homebirths, in lieu of using Maven.

Date of Birth:		Birthplace or Facility:	
Baby's Last Name:		Transferred to:	
Baby's First Name:		Accession#:	
Mother's Last Name:		Gender:	
Mother's First Name:		Mother's Phone#:	
Mother's Address:			

Hearing Screening Results:

Date:		Method:	☐OAE ☐ABR	Right:	☐Not Screened ☐Pass ☐Fail	Left:	☐Not Screened ☐Pass ☐Fail
Date:		Method:	☐OAE ☐ABR	Right:	☐Not Screened ☐Pass ☐Fail	Left:	☐Not Screened ☐Pass ☐Fail
Facility Screened at:				Name of Screener:			
Please explain "Not Screened":	☐NICU\Illness ☐Equipment Issue (Notify EHDI) ☐Refused ☐Discharged Early ☐Transferred to: ☐Other, please explain:						

Congenital Cytomegalovirus Results (*required before 21 days old if failed NBHS*):

Test Date:		Type:	☐Not Tested ☐PCR-Urine ☐PCR-Saliva ☐Urine-Culture ☐Other:	Lab Name:	
Date Results Rec'd:		Result:	☐Not Detected ☐Detected ☐Inconclusive ☐Unsatisfactory Specimen ☐Unknown	Symptoms:	☐None ☐Mother CMV+ ☐Unknown
Please explain "Not Tested":	☐NICU\Illness ☐Refused ☐Discharged Early ☐Transferred to: ☐Other, please explain:				

Referral to Audiology (*required if failed NBHS*):

Appointment Date:		Audiology Center:	☐Connecticut Children's Medical Center (860)545-9642 ☐Lawrence & Memorial Hospital (860) 271-4900 ☐UCONN., Speech & Hearing Clinic (860) 486-2629 ☐Yale New Haven Children's Hospital (877) 925-3637 ☐Other:

Primary Care Provider

Name:	
Phone\Fax:	
Address:	

Please fax, secure email, or mail this form to:

Connecticut Department of Public Health (**DPH**)

Early Hearing Detection and Intervention (EHDI) Program

410 Capitol Avenue, MS# 11 MAT, P.O. Box 340308

Hartford, CT 06134-0308

Fax to: (860) 629-6965. Email: dph.ehdi@ct.gov. Questions or concerns? Call (860) 509-8251. *V.09/13/22*