State of Illinois
Illinois Department of Public Health

Early Hearing Detection and Intervention (EHDI)
LOCAL HEALTH DEPARTMENT Hearing Screening Follow-up Report

Please Print

Child's Name _____ ID # _____

Other names this child may also be known as:

_____

Date of Birth _____ Sex: ❑ Male ❑ Female

Birth Hospital _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

_____
(City) (State) (ZIP) (County) (Phone)

Physician's **FULL** Name _____

Phone _____ FAX _____

Screener's Name &Title _____

Address _____

Phone _____ Date of Testing: _____

PER THE JOINT COMMITTEE ON INFANT HEARING: TESTING OF BOTH EARS SHOULD BE COMPLETED ON THE SAME DAY

Screening Technology Used: ❑ DPOAE ❑ Other ❑

Screening Results:

Right Ear Result	❑ **Pass**	❑ **Refer**
Left Ear Result	❑ **Pass**	❑ **Refer**

Notes / Action plan:

Illinois Department of Public Health Early Hearing Detection and Intervention
535 W. Jefferson St., 2nd floor
Springfield, IL 62761
217-782-4733

This form may be faxed to: 217-557-5324
OR
E-mailed to: ***dph.hearingreports@illinois.gov***

within 7 days of testing

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