



Hearing Out-Patient Screening Form

Arizona Department of Health Services

Early Hearing Detection and Intervention

Contact Name: _____ Please submit within one week of testing
 Contact Phone: _____ Fax to 602-364-1495

Patient Last Name:	Date of Birth:	Sex:
Patient First Name:	Birth Order (if multiple births) A B C D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Test/Screen:	
Primary Physician:	Results: Right	Left
Notes:		Type of Test: OAE ABR

Patient Last Name:	Date of Birth:	Sex:
Patient First Name:	Birth Order (if multiple births) A B C D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Test/Screen:	
Primary Physician:	Results: Right	Left
Notes:		Type of Test: OAE ABR

Patient Last Name:	Date of Birth:	Sex:
Patient First Name:	Birth Order (if multiple births) A B C D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Test/Screen:	
Primary Physician:	Results: Right	Left
Notes:		Type of Test: OAE ABR