North Carolina Early Hearing Detection and Intervention Program
Screening/Rescreening Reporting Form

Patient Information
Child’s Name: ___________________________ DOB: ____________
Mother’s Name: __________________________________
Home Address: __________________________________
____________________________________________________________________________________
Sex: [ ] Male  [ ] Female  Multiple Birth: [ ] Yes  [ ] No

Initial Screening
Facility Name: ___________________________  Facility EIN ____________
Date of screening: __________
Technology Used:  [ ] AABR  [ ] DPOAE  [ ] TEOAE  [ ] Screening BAER
Right Ear Result:  [ ] Pass  [ ] Refer  [ ] Not screened (explain) ________________
Left Ear Result:  [ ] Pass  [ ] Refer  [ ] Not screened (explain) ________________

Rescreening
Facility Name: ___________________________  Facility EIN ____________
Date of screening: __________
Technology Used:  [ ] AABR  [ ] DPOAE  [ ] TEOAE  [ ] Screening BAER
Right Ear Result:  [ ] Pass  [ ] Refer  [ ] Not screened (explain) ________________
Left Ear Result:  [ ] Pass  [ ] Refer  [ ] Not screened (explain) ________________

Mail Form To:
ATTN: Data Specialist
Early Hearing Detection and Intervention Program
1928 Mail Service Center
Raleigh, NC 27699-1928

or
Fax Form To:
ATTN: Data Specialist
(919) 870-4881