Med ID # _____

REQUIRED CMV LAB TESTING REPORT

For infants failing newborn hearing screening

Version 4:
Dec 2014

TO: _____, Clinic _____, Fax _____

FROM: _____, Facility _____, Fax_____

1. Date Faxed: _____ (completed by NBHS screener, faxed to PCP *AND* documented in Hi*Track):

The following infant, who lists you as their Primary Care Physician, has **FAILED** the **INITIAL** newborn hearing screen and will **REQUIRE** a follow-up hearing screen ***no later than 14 days of age***. Please encourage the family to keep the following re-screening appointment.

FAILING INITIAL hearing screening				
Infant's Name	**D.O.B.**	**Mother's Name**	**Contact#**	**Follow-up Appt.**

2. Date Faxed: _____ (completed by NBHS screener, faxed to PCP *AND* UDOH, documented in Hi*Track)

The following infant has **FAILED** the **FOLLOW-UP (2nd)** hearing screen. **CONGENITAL CMV testing is required BEFORE THE INFANT IS 21 days of age** per Utah Cytomegalovirus **(CMV) Testing Mandate.**

FAILING follow-up hearing screening

CMV LAB TESTING NEEDS TO BE ORDERED BY PHYSICIAN (Saliva/Urine)

Infant's Name	**D.O.B.**	**Mother's Name**	**Contact#**	**Diagnostic Appt.**

The following infant has ***PASSED*** the **FOLLOW-UP (2nd)** hearing screening. *No further action is necessary.*				
Infant's Name	**D.O.B.**	**Mother's Name**	**Contact#**	**Date Passed**

3. Date Faxed: _____ (PHYSICIAN enter lab results below and fax to (801) 584-8492)

CMV LAB TESTING RESULTS MUST BE ENTERED BELOW AND FAXED to Utah Department of Health Early Hearing Detection and Intervention (EHDI) at **(801) 584-8492 WITHIN 10 DAYS OF RECEIPT.**

Infant's Name	**D.O.B.**	**Date of CMV Test**	**Urine (U) or Saliva (S)**	**RESULT: Detected (+) or Not Detected (-)**	**N/A: Family DECLINED***

*If family declines CMV testing, please have family fill out and sign the *CMV Testing Declination Form* (available at health.utah.gov/CMV) and fax it with this form.