UTAH DEPARTMENT OF HEALTH

Utah Newborn Hearing Screening *Weekly* Reporting Form

Please Print Clearly and fill out all that applies

_____ **Date**

_____ **Midwife** _____ **Screener** _____ **Facility**

Baby's Name & ID (Heelstick)	Baby's Info	Mom's Information	Initial Screen/ Rescreen **Both Ears must be tested on Rescreen**	RIGHT Ear	LEFT Ear	Baby's Pediatrician or MD	CMV info to parent & referral made to PED/MD?	Place of Birth
	Baby's DOB:	Mom's Name: Mom's DOB: Address:	Initial Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Name: _____	Info Given ☐	Birthing Center ☐
	Gender:	Phone:	Rescreen Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Facility: _____	Referral Date : ☐	Home ☐
	Baby's DOB:	Mom's Name: Mom's DOB: Address:	Initial Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Name: _____	Info Given ☐	Birthing Center ☐
	Gender:	Phone:	Rescreen Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Facility: _____	Referral Date : ☐	Home ☐
	Baby's DOB:	Mom's Name: Mom's DOB: Address:	Initial Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Name: _____	Info Given ☐	Birthing Center ☐
	Gender:	Phone:	Rescreen Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Facility: _____	Referral Date : ☐	Home ☐
	Baby's DOB:	Mom's Name: Mom's DOB: Address:	Initial Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Name: _____	Info Given ☐	Birthing Center ☐
	Gender:	Phone:	Rescreen Date: _____	Pass ☐ Refer ☐	Pass ☐ Refer ☐	Facility: _____	Referral Date : ☐	Home ☐

Please fax to 801-536-0492 or email courtneysteele@utah.gov