

**Early Hearing Detection and Intervention Direct Referral Form
for Diagnostic Audiology Evaluation**

Communicating Did Not Pass Results

Congratulations on the birth of your baby. We just finished screening your baby's hearing. Your baby did not pass two hearing screenings. This does not necessarily mean that your baby has a hearing loss, but without additional testing we can't be sure. Funding for follow-up testing can be found through private insurance, Medicaid, Children's with Special Healthcare Services (CSHCS), or private pay. If you would like to use Medicaid, private insurance, or pay for the services yourself, we will help you make the follow-up appointment before you leave the hospital. If you are interested in applying for CSHCS, we will assist you in getting the appropriate paperwork. If this form is being provided after hours or on the weekend, the hospital staff will be contacting you at home with the time and date of the appointment.

Central Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Methodist Hospital
1701 N Senate Blvd AGO45
Indianapolis, IN 46202
Phone: (317) 962-9830
Fax: (317) 962-9834

Pediatric Ear Nose & Throat
Center Peyton Manning Children's
Hospital at St. Vincent
86th St. Campus
8402 Harcourt Rd, Suite 732
Indianapolis, IN 46260
Phone: (317) 338-6815
Fax: (317) 338-6582

Riley Hospital for Children
702 Barnhill Dr #0860
Indianapolis, IN 46202
Phone: (317) 944-8868
Fax: (317) 944-6680

Outreach Services for Deaf and
Hard of Hearing Children
Indiana School for the Deaf
1200 E 42nd St
Indianapolis, IN 46205
Phone: (317) 920-6347
Toll Free (800) 724-9550
Fax: (317) 920-6350

St. Vincent Hospital
2001 West 86th Street
Indianapolis, IN 46260
Phone: (317) 338-3224
Fax: (317) 338-2366
Zionsville office:
(317) 344-1290
The Northeast Office:
(317) 415-9260
(317) 415-9264 Fax

Appointment: Scheduled Needs to be Scheduled Interpreter-Type Needed: _____

Date: _____ Time: _____

Newborn Information

Name: _____ Date of Birth: _____

Birth Facility: _____ Screening Facility: _____

Hearing Screening Date: _____ MRN: _____

Hearing Screening Results: Right Pass Refer Left Pass Refer

Funding for follow-up: Medicaid Self Pay Private Insurance _____

Parent/Guardian Contact Information

Name: _____ Language Spoken at Home: _____

Address: _____

Phone #: _____ Alternate Phone #: _____

Alternate Contact (Friend/Relative)

Name: _____ Alternate Phone #: _____

Primary Care Provider

Name: _____ Phone #: _____

Diagnosis: Suspected Hearing Loss **Diagnosis Code:** 389.9 **This order is valid for six (6) months from the date ordered.**

Physician Authorizing Diagnostic Audiology Evaluation As the Primary Care Provider, you must sign below and fax back to the facility selected above at least 7 days before the above scheduled appointment or it will be cancelled. Signature must be that of the physician. A copied signature is acceptable.

Physician Signature: _____

Date: _____