

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.

Northwestern Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Community Hospital—Munster
901 MacArthur Blvd
Munster, IN 46321
219-836-4527
219-836-6752 fax

Family Hearing Center
2134 College Ave
Goshen, IN 46528
574-533-2222
574-533-6868 fax
(Most Medicaid)

Franciscan Alliance-St. Margaret Health
24 Joliet Street (US Route 30)
Dyer, IN 46311
219-933-2635 (to schedule appt)
219-933-2094 (audiology dept)
219-933-2158 fax
(Most Medicaid)

ENT of Michiana
100 Navarre Pl. Suite 4430
South Bend, IN 46601
574-246-1000
574-246-4000 fax
(Only Medwise Select Medicaid)

**Outreach Services for Deaf
& Hard of Hearing Children**
Indiana School for the Deaf
1200 E. 42nd Street
Indianapolis, IN 56205
800-724-9550 (toll free)
317-920-6350 fax

South Bend Clinic
211 N. Eddy Street
South Bend, IN 46617
574-237-9200
574-237-9329 fax
(Most Medicaid)

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

Date: _____

Time: _____

Newborn Information

Name: _____

Date of Birth: _____

Birth Facility: _____

Screening Facility: _____

Hearing Screening Date: _____

Hearing Screening Results: Right Pass Refer

Left Pass Refer

Funding for follow-up: Medicaid CSHCS Self Pay

Private Insurance _____

Parent/Guardian Contact Information

Name: _____

Language Spoken at Home: _____

Address: _____

Phone #: _____

Alternate Phone #: _____

Alternate Contact (Friend/Relative)

Name: _____

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: _____