

Appendix F

Direct Referral Forms

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

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

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
Pediatric ENT Center
Medical Center Northeast
13914 E State Rd 238,
Suite 108
Fishers, IN 46037
(317) 338-6815
Medicaid/Unsedated/Awake

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

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

Date: _____

Time: _____

Newborn Information

Name: _____

Date of Birth: _____

Birthing Facility: _____

Screening Facility: _____

Hearing Screening Date: _____

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: _____

Phone #: _____

Alternate Phone #: _____

Primary Care Provider

Name: _____

Phone #: _____

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: _____

Date: _____

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Northeast Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Advanced Hearing Care
1827 N Madison Ave Suite C
Anderson, IN 46011
Phone: (765) 608 3277
Fax: (765) 608-3278

ENT Associates
10021 Dupont Circle Ct.
Fort Wayne, IN 46825
Phone: (260) 426-8117
X1626
Fax: (260) 416-0347

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

Parkview Hospital
2200 Randallia
Fort Wayne, IN 46805
Phone: (260) 373-4527
Fax: (260) 373-2479

Ball State University
AC 104
Muncie, IN 47306
Phone: (765) 285-8160
Fax: (765) 285-5623

MCHA Hearing Solutions
442 W High St
Bryan, OH 43506
Phone: (419) 636-4517
Fax: (419) 636-6438

St John's Health System
2015 Jackson St
Anderson, IN 46016
Phone: (765) 646-8172
Fax: (765) 608-3909

Appointment: Scheduled Needs to be Scheduled

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: _____

Address: _____

Phone #: _____

Alternate Phone #: _____

Primary Care Provider

Name: _____

Phone #: _____

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Northwestern Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Community Hospital Munster
901 MacArthur
Munster, IN 46321
Phone: (219) 836-4527
Fax: (219) 836-6752

Family Hearing Center, Inc.
2134 College Ave
Goshen, IN 46528
Phone: (574) 533-2222
Fax: (574) 533-6868

St Margaret Mercy
5454 Hohman Ave
Hammond, IN 46320
Phone: (219) 933-2094
Fax: (219) 933-2158

ENT of Michiana
100 Navarre Pl Suite 4430
South Bend, IN 46601
Phone: (574) 246-1000
Fax: (574) 246-4000

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

The Hearing Clinic
Centennial Market Square
621 Memorial Dr Ste 402
PO Box 1916
South Bend, IN 46634
Phone: (574) 232-4040
Fax: (574) 288-7143

Appointment: Scheduled Needs to be Scheduled

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: _____

Address: _____

Phone #: _____

Alternate Phone #: _____

Primary Care Provider

Name: _____

Phone #: _____

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Signature: _____

Date: _____

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Southeastern Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Cincinnati Children's Hospital
333 Burnet Ave ML2002
Cincinnati, OH 45229
Phone: (513) 636 4236
Fax: (513) 636-7316

Doctor's Hearing Care
4212 Charlestown Rd Suite 3
New Albany, IN 47150
Phone: (812) 949-3272
Fax: (812) 949-3271

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

Columbus Regional Hospital
3015 10th St
Columbus, IN 47201
Phone: (812) 376-5319
Fax: (812) 375-3702

Heuser Hearing Institute
117 E Kentucky St
Louisville, KY 40203
Phone: (502) 584-3573
Fax: (502) 583-6364

University Audiology Associates
601 S Floyd St # 600
Louisville, KY 40202
Phone: (502) 583-3277 or
(502) 629-7710
Fax: (502) 587-7473

Kosair Children's Hospital
231 E Chestnut St
Louisville, KY 40202
Phone: (502) 629-6200
Fax: (502) 629-7915

Appointment:

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: _____

Address: _____

Phone #: _____

Alternate Phone #: _____

Primary Care Provider

Name: _____

Phone #: _____

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Southwestern Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Easter Seals Rehabilitation Center
3701 Bellemeade Ave
Evansville, IN 47714
Phone: (812) 479-1411
Fax: (812) 437-2636

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

Appointment: Scheduled Needs to be Scheduled

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: _____

Address: _____

Phone #: _____ Alternate Phone #: _____

Primary Care Provider

Name: _____ Phone #: _____

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West Central Indiana Locations for Follow-up Testing

(Please mark the location chosen for follow-up)

Purdue University
1353 Heavilon Hall
West Lafayette, In 47907
Phone: (765) 494-3789
Fax: (765) 494-0771

Witham Health Services
2485 North Lebanon St
Lebanon, IN 46052
Phone: (765) 482-8687
Fax: (765) 483-8687

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) 920-63

Appointment: Scheduled Needs to be Scheduled

Date: _____

Time: _____

Newborn Information

Name: _____

Date of Birth: _____

Birth Facility: _____

Screening Facility: _____

Hearing Screening Date: _____

Hearing Screening Results: Right Pass Refer

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Parent/Guardian Contact Information

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