DIAGNOSTIC AUDIOLOGY EVALUATION (DAE)

State Form 53233 (R3 / 2-25)
Indiana Department of Health
Indiana's Early Hearing Detection and Intervention (EHDI) Program www.hearing.in.gov

Reset Form

Instructions: Use this form to report to the Indiana State Department of Health:

1) Babies requiring follow-up from Universal Newborn Hearing Screening (UNHS).

2) Babies who did not receive UNHS, and any additional children diagnosed with permanent hearing loss.

3) Please fax completed form to 317-925-2888. Questions? Contact the EHDI Program at 317-233-1264

Patient Information:		Office ID/MRN	
Child's Last Name		Child's First Name	
Date of Birth *(month,day,year)*		Child's Sex ☐ Male ☐ Female	
Birthing Facility		UNHS Results ☐ Pass ☐ Did Not Pass ☐ Unknown	
Born out of state ☐ Y ☐ N Born out of country ☐ Y ☐N		LANGUAGE IN HOME:	
School District:		Foster/Adopted ☐Y ☐N	If Yes, list contact info below
Mother's Last Name		Mother's First Name	
Mother's Current Address *(Street, City, State, and ZIP)*		Mother's Telephone Number	
		Mother's Email	
Primary Care Physician *(PCP)* Name		PCP Current Address *(Street, City, State and ZIP)* and Telephone Number	

Date of Evaluation __ __ / __ __ /__ __ ☐ **Initial Report** ☐ **Follow-Up Report**

Audiologist	Email
Clinic Name and Current Address *(Street, City, State, and ZIP)*	Telephone Number

Case History:

☐ Special Care/NICU (more than five (5) days) ☐ Family History of Childhood Hearing Loss ☐ Parental Concern

☐ Hyperbilirubinemia requiring exchange transfusion ☐ Genetic Syndromes associated with hearing loss (_____)

☐ Craniofacial Anomalies ☐ Bacterial Meningitis ☐ Ototoxic Medications ☐ Mechanical Ventilation ☐ ECMO

☐ In-utero Infection ☐ CMV ☐ Syphillis ☐ Rubella ☐ Herpes ☐ Toxoplasmosis ☐ Other (_____)

Methods of Evaluation:

☐ Click ABR	☐ Screening ABR	☐ TEOAE	☐ BOA	☐ High Frequency Tympanometry		
☐ Toneburst ABR	☐ ASSR	☐ DPOAE	☐ VRA	☐ Tympanometry (220/226)		☐ MEMR
☐ Bone Conduction ABR			☐ CPA	☐ Sound Field	☐ Conventional	

Audiologic Results:

Left Ear Type	Left Ear Degree	Right Ear Type	Right Ear Degree
☐ Normal	☐ Normal *(0-20 dB HL)*	☐ Normal	☐ Normal *(0-20 dB HL)*
☐ Temp Conductive	☐ Slight *(16-25 dB HL)*	☐ Temp Conductive	☐ Slight *(16-25 dB HL)*
☐ Perm Conductive	☐ Mild *(21-40 dB HL)*	☐ Perm Conductive	☐ Mild *(21-40 dB HL)*
☐ Mixed	☐ Moderate *(41-55 dB HL)*	☐ Mixed	☐ Moderate *(41-55 dB HL)*
☐ Sensorineural	☐ Moderately-Severe *(56-70 dB HL)*	☐ Sensorineural	☐ Moderate-Severe *(56-70 dB HL)*
☐ Auditory Neuropathy	☐ Severe *(71-90 dB HL)*	☐ Auditory Neuropathy	☐ Severe *(71-90 dB HL)*
☐ Undetermined	☐ Profound *(91 + dB HL)*	☐ Undetermined	☐ Profound *(91 + dB HL)*
	☐ Undetermined		☐ Undetermined

Comments:

Additional Recommendations/Resources:

☐ Medical Follow-up with PCP	☐ Enrolled in First Steps ☐ Referred to First Steps
☐ Medical Follow-up with ENT	☐ Hearing Aid(s) ☐ Cochlear Implant(s) ☐ Other
ENT Provider: Telephone Number:	☐ Communication Assessment (Spoken/Visual)
☐ Referral for Genetics	☐ Family Resource Guide ☐ SKI*HI Parent Advisor/Family Education
Genetics Provider: Telephone Number:	☐ Other EI Services_____
☐ Referral for Vision Screening/Evaluation_____	
☐ Audiologic Monitoring: ☐ in ____ months ☐ in_____weeks Scheduled Follow-up Date *(month,day,year)*:_____	

Results Communicated to: ☐ PCP ☐ ENT ☐ Parent/Family ☐ First Steps ☐ GBYS ☐ Other _____