Arkansas Department of Health
Infant Hearing Program
501-280-4170 fax

Post-Discharge Hearing Screen Form

Please Stamp Here ONLY!

Insert Medical Record Number in this Space

Facility #

Date of Birth (MM-DD-YYYY) / /

Infant's Last Name (Please Print in CAPITAL LETTERS)

Infant's First Name (Please Print in CAPITAL LETTERS) M.I.

Mother's Last Name (Please Print in CAPITAL LETTERS)

Mother's First Name (Please Print in CAPITAL LETTERS)

Test Date (MM-DD-YYYY) / /

○ Missed ○ Rescreen

Method of Screening ○ (A)ABR ○ OAE

Right Ear	Left Ear	
○	○	Passed
○	○	Did Not Pass
○	○	Further testing required

This Section to be completed, only if there has been a change

Infant's Address (Please Print in CAPITAL LETTERS)

City (Please Print in CAPITAL LETTERS) State Zip

Mother's Phone Number - -

Infant's PCP/ Clinic _____

PCP #