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Contact: Healthy_Hearing@health.qld.gov.au

Queensland Government

Healthy Hearing Program

Newborn Hearing Screening and Referral

Facility: ....

(Affix identification label here)
BABY'S LABEL
URN:
Family name:
Given name(s):
Address:
Date of birth:
Sex: ☐ M ☐ F ☐ I

Alternative contact and relationship information:
(FOB: Father of baby, MGF: Maternal grandfather, PGM Paternal grandmother, Aunt of baby etc, Friend)
Name (1): ....
Phone number: .... R'ship ....
Name (2): ....
Phone number: .... R'ship ....
Medical contact:
Name: ....
Address: ....
....

(Affix identification label here)
MOTHER'S LABEL
URN:
Family name:
Given name(s):
Address:
Date of birth:

Baby's details

UR Number .... (enter UR number for hospital where screen is performed)
Hospital of birth .... (enter approved HHP code for facility site)
Gestational age at birth: .... weeks (enter number in whole weeks only)
Location of Screen: ☐ Maternity ☐ ICN ☐ SCN ☐ Birth Suite / Centre ☐ OPD ☐ Home ☐ Community ☐ Paed Ward
Indigenous Status: ☐ **1.** Aboriginal ☐ **2.** Torres Strait Islander ☐ **3.** Aboriginal and Torres Strait Islander
☐ **4.** Not Aboriginal or Torres Strait Islander ☐ **9.** Not stated

High risk indicators (If *'yes'*, Audiology surveillance is required: copy of completed form to be sent to Audiology)

☐ Yes ☐ No Family history of permanent childhood hearing loss (**mother / father / siblings of baby only**) excluding grommets / ear infection / trauma Details: ....
☐ Yes ☐ No ***Syndromes associated with hearing loss** (e.g. Downs, Pierre Robin) Details: ....
☐ Yes ☐ No Prolonged ventilation ≥ 120 hours (IPPV / CPAP / HHFNCT) Number of hours: ....
☐ Yes ☐ No Bacterial meningitis Details: ....
☐ Yes ☐ No Severe asphyxia at birth (convulsions / HIE / PPHN) Details: ....
☐ Yes ☐ No ***Craniofacial anomalies** eg. cleft palate (**exclude** cleft lip and skin tags) Details: ....
☐ Yes ☐ No Hyperbilirubinemia levels ≥ exchange transfusion range as per appropriate Nomogram for the baby
See over for required evidence. Highest SBR level: .... µmol/l Date: / / Age in hours: ....
☐ Yes ☐ No Perinatal Infection of the baby (confirmed / suspected): ☐ Toxoplasmosis ☐ Rubella ☐ CMV ☐ Herpes ☐ Syphilis
☐ Yes ☐ No Professional / other major medical concerns / Chemotherapy Details: ....

AABR 1 screening results

Date: .... Time: ....
Right Ear: ☐ Pass ☐ Refer
Left Ear: ☐ Pass ☐ Refer
☐ Milestones, monitoring, otitis media discussed
Name:
....
Designation:
....
Signature:
....
Comments:
....
....
....
....

AABR 2 screening results

Date: .... Time: ....
Right Ear: ☐ Pass ☐ Refer
Left Ear: ☐ Pass ☐ Refer
☐ Milestones, monitoring, otitis media discussed
Name:
....
Designation:
....
Signature:
....
Comments:
....
....
....
....

Follow up actions

☐ **OPD Screening app't on** .... **at** ....
☐ **Result reversal (Flip Flop):** AABR3 required → see page 2
☐ **Information letter to:** ....
re: ☐ Pass with risk factors ☐ Parental decline
☐ FTA / LTF Date letter sent: ....

Referral process

☐ **Refer to Audiology at:** ....
Date of referral sent: ....
for: ☐ Audiology **ABR** assessment
☐ Brochure provided to family for **ABR**
OR
for: ☐ ***Early targeted surveillance by 6 weeks**
☐ Targeted surveillance by **first birthday**
☐ Brochure provided to family for Early T/S or T/Surv
☐ **Refer to Family Support Facilitator (QHLFSS)**
Date referral sent to QHLFSS: ....
(Direct Refers only)
Interpreter required: ☐ Yes ☐ No
Language: ....

Screen not completed

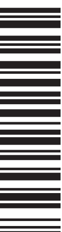
☐ Baby not screened at this facility
☐ Declined to screen
☐ Transferred to: ....
☐ Failed to attend (FTA) / Lost to follow up (LTF)
☐ Audiology → Medical exclusion **Microtia / Atresia** of any ear ....
☐ Audiology → Clinician override / Too ill to screen ....
☐ Screen incomplete at this facility
☐ Baby died after birth Date: ....
Date: ....

DO NOT WRITE IN THIS BINDING MARGIN

NEWBORN HEARING SCREENING AND REFERRAL

v13.00 - 06/2022

SW012



Available from WINC Code 1NY31670

Queensland Government

Healthy Hearing Program

Newborn Hearing Screening and Referral

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URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

BABY'S LABEL

AABR 3 screening results

If required after result reversal (flip flop)

Date: .... Time: ....

Right Ear: ☐ Pass ☐ Refer
Left Ear: ☐ Pass ☐ Refer

☐ Milestones, monitoring, otitis media discussed

Name: ....

Designation: .... Signature: ....

Comments: ....

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth:

MOTHER'S LABEL

Aborted screen documentation

Aborted by Screener:	Aborted by Screener:	Aborted by Screener:
☐ Impedance ☐ Myogenic/EEG ☐ Background noise ☐ Lack of ABR progress	☐ Impedance ☐ Myogenic/EEG ☐ Background noise ☐ Lack of ABR progress	☐ Impedance ☐ Myogenic/EEG ☐ Background noise ☐ Lack of ABR progress
Date:	Date:	Date: ....
Name:	Name:	Name: ....

High risk Factor: Hyperbilirubinemia documentation

* Screener must attach a completed copy of the baby's plotted *Queensland Clinical Guidelines Nomogram* appropriate for baby's **gestation, weight, age** and **risks**. https://www.health.qld.gov.au/qcg

If plotted Nomogram "with risk factors" has been selected - **please circle appropriate risk/s:**
Sepsis / Haemolysis / Acidosis / Asphyxia / Other as nominated by Neonatologist ....

Additional notes (May be used, as required, to record additional data and free text notes)

Date / Time	*Add signature, printed name, staff category, date and time to all entries* MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries

DO NOT WRITE IN THIS BINDING MARGIN

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