

Early Hearing Detection and Intervention (EHDI)

Patient Checklist for Pediatric Medical Home Providers

Patient Name: _____

Date of Birth: ____/____/____

Birth	Hospital-based Inpatient Screening Results (OAE/AABR) (also Home Births) DATE: ____/____/____
	Left ear: <input type="checkbox"/> Missed <input type="checkbox"/> Incomplete <input type="checkbox"/> Failed Screen ^{a, c} <input type="checkbox"/> Pass Right ear: <input type="checkbox"/> Missed <input type="checkbox"/> Incomplete <input type="checkbox"/> Failed Screen ^{a, c} <input type="checkbox"/> Pass
Before 1 month	Outpatient Screening Results (OAE/AABR) ____/____/____
	Left ear: <input type="checkbox"/> Incomplete <input type="checkbox"/> Failed Re-Screen ^{a, c} <input type="checkbox"/> Pass Right ear: <input type="checkbox"/> Incomplete <input type="checkbox"/> Failed Re-Screen ^{a, c} <input type="checkbox"/> Pass
Before 3 months	<input type="checkbox"/> Pediatric Audiology Evaluation^b ____/____/____ <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Normal Hearing <input type="checkbox"/> Document child and family auditory history ____/____/____ <input type="checkbox"/> Report to State EHDI Program results of diagnostic evaluation ____/____/____ <input type="checkbox"/> Refer to Early Intervention (IDEA, Part C) ____/____/____ <input type="checkbox"/> Advise family about communication options and assistive listening devices (hearing aids, cochlear implants, etc.) ____/____/____ <input type="checkbox"/> Medical & Otologic Evaluations to recommend treatment and provide clearance for hearing aid fitting ____/____/____ <input type="checkbox"/> Pediatric Audiology for hearing aid fitting and monitoring ____/____/____
Before 6 months	<input type="checkbox"/> Enrollment in Early Intervention (IDEA, Part C) ____/____/____ (transition to Part B at 3 years of age) <input type="checkbox"/> Medical Evaluations to determine etiology and identify related conditions ____/____/____ <input type="checkbox"/> Otolaryngology (required) ____/____/____ <input type="checkbox"/> Ophthalmologist (recommended) ____/____/____ <input type="checkbox"/> Geneticist (recommended) ____/____/____ <input type="checkbox"/> Developmental pediatrics, neurology, cardiology, and nephrology (as needed) ____/____/____ <input type="checkbox"/> Ongoing Pediatric Audiology Services ____/____/____

Ongoing Care of All Infants^d

Provide parents with information about hearing, speech, and language milestones

Identify and aggressively treat middle ear disease

Vision screening and referral as needed

Ongoing developmental surveillance/referral

Risk indicators for delayed-onset hearing loss:

(If risk factors are present, refer for audiology evaluation at least once prior to age 30 months)

Service Provider Contact Information

Pediatric Audiologist:

Early Intervention Service Coordinator:

Other:

Other:

Other:

(a) In screening programs that do not provide Outpatient Screening, infants will be referred directly from Inpatient Screening to Pediatric Audiologic Evaluation. Likewise, infants at higher risk for hearing loss (or loss to follow-up) also may be referred directly to Pediatric Audiology.

(b) Part C of IDEA* may provide diagnostic audiologic evaluation services as part of Child Find activities.

(c) Even infants who fail screening in only one ear should be referred for further testing of both ears

(d) Includes infants whose parents refused initial or follow-up hearing screening.

OAE = Otoacoustic Emissions
AABR = Automated Auditory Brainstem Response
ABR = Auditory Brainstem Response
IDEA = Individuals with Disabilities Education Act
EHDI = Early Hearing Detection & Intervention

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