

CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NEWBORN HEARING SCREENING REPORTING FORM

Birth Place		Mother's Last Name		First	
Accession #		Baby's Medical Record Number			
Baby's Last Name		First		Address	
Date of Birth		Weight (grams)		EGA (weeks)	
Birth Sequence		Sex:	☐ Male ☐ Female	Race	
Hospital Transferred to					

HEARING SCREENING					
Date		Method		Right	
				Left	
Date		Method		Right	
				Left	
Primary Care Provider Name					Telephone
PCP Address					

Please return this form to: Connecticut Department of Public Health
Early Hearing Detection and Intervention Program
410 Capitol Avenue, MS# 11 MAT, P.O. Box 340308
Hartford, CT 06134-0308

or Fax to: (860) 509-8132

Contact the CT EHDI Program at (860) 509-8057 with any questions.