CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NEWBORN HEARING SCREENING REPORTING FORM

Birth Place HOME BIRTH

Mother's Last Name **First**

Accession # / / / / / / /

Baby's Medical Record Number

Baby's Last Name **First**

Address **Telephone** ( ) -

Date of Birth / / **Weight (grams)** **EGA (weeks)**

Birth Sequence **Sex:** ☐ **Male** ☐ **Female** **Race**

Hospital Transferred to

Primary Care Provider Name **Telephone** ( ) -

PCP Address

HEARING SCREENING

Date / / **Method** **Right** **Left**

Date / / **Method** **Right** **Left**

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.