State of Illinois
Illinois Department of Public Health

Early Hearing Detection and Intervention
Physician Follow-up Report

Child's Name _____ Med. ID _____

Other names this infant may also be known as:

_____

Date of Birth _____ Sex: ❑ Male ❑ Female

Birth Hospital _____

Mother/Guardian Name _____
(Last) (First) (MI)

Address _____
(Street) (Apt.#)

_____
(City) (State) (ZIP) (County) (Phone)

Physician's **FULL** Name _____

Phone _____ FAX _____

Name of Person Completing Form _____ Date Completed _____

❑ A **Diagnostic** Evaluation was Performed

Where _____ When (Date) _____

❑ A **Re-Screening** was Performed (From Records, Not Parent Report)

Where _____ When (Date) _____

Type Of Screening: ❑ DPOAE ❑ TEOAE ❑ Automated ABR

Right Ear Result _____ Left Ear Result _____

❑ An **Appointment** has been Scheduled

Where _____ When (Date) _____

❑ Other (Specify) _____

NOTES

Illinois Department of Public Health
Early Hearing Detection and Intervention
535 W. Jefferson St., 2nd floor
Springfield, IL 62761
217-782-3300

This form may be faxed to: 217-524-4201
OR
E-mailed to: ***dph.hearingreports@illinois.gov***