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** **Telephone** ( ) -

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

PCP Address

Telephone ( ) -

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.