Child and Family Health Service

REFERRAL TO UNIVERSAL NEONATAL HEARING SCREENING

CLIENT LABEL

ID Number: .....

Surname: .....

Given Names: .....

D.O.B: ..... Sex: .....

Universal Neonatal Hearing Screening
295 South Terrace, Adelaide, SA 5000
Phone: (08) 8303 1585 Fax: (08) 8303 1640

Thank you for seeing, Date:...../...../.....

Child's Name: ..... Date of Birth:...../...../..... Age (Weeks): .....

Postal Address: ..... Postcode: .....

Parent / Guardian / Caregiver Name: .....

Home Phone: ..... Mobile Phone: .....

Is English the first language? ☐Yes ☐No Interpreter required? ☐Yes ☐No Language: .....

Newborn Hearing Screening Results AABR = Automated Auditory Brainstem Response

1st AABR	Date:...../...../.....		2nd AABR	Date:...../...../.....	
PASS (P) / REFER (R) / DECLINE (D)	LEFT	RIGHT	PASS (P) / REFER (R) / DECLINE (D)	LEFT	RIGHT

Additional Notes: .....

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Would the client be willing to travel to South Terrace, Adelaide if an earlier appointment was available? ☐Yes ☐No

Referring Details:

Name: ..... Signature: ..... Date:...../...../.....

CaFHS Site: ..... Contact number: .....

On completion, please fax to (08) 8303 1640

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