LEVEL 2 SCREEN

Maryland State Department of Health and Mental Hygiene

OGCSHCN Room 421A, 201 West Preston Street, Baltimore, MD 21201

1-800-633-1316 Or 410-767-6730

POST DISCHARGE INFANT HEARING SCREENING

PLEASE COMPLETE ALL INFORMATION REQUESTED.

LEVEL 2 SCREEN

BIRTH LAST NAME (include birth order if multiple birth)

Date of Birth ☐☐/☐☐/☐☐☐☐

Hospital of Birth ☐☐☐ (See Back forCode)

○ Male ○ Female

PERMANENT NAME:

Last First

(Special Notes - See Back for Instructions)

Family's Primary Language

MOTHER

Mother's Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Mother's First Name Last Name

Address

City State Zip Code

Phone (☐☐☐) ☐☐☐-☐☐☐☐

PEDIATRICIAN

Physician's Last Name Physician's First Name

Practice/Group Name

Physician's Address

City State Zip Code

Physician's Phone (☐☐☐) ☐☐☐-☐☐☐☐

REPORT OF LEVEL 2 HEARING SCREENING

SCREENING PROVIDER

Practice/Group Name

Address

City State Zip Code

Provider's Phone (☐☐☐) ☐☐☐-☐☐☐☐

Provider's Last Name First Name

SCREENING RESULTS:

Date of Test ☐☐/☐☐/☐☐☐☐

○ No Show

Type of Test	Right Ear	Left Ear
○ OAE	○ Pass	○ Pass
○ ABR	○ Fail	○ Fail
	○ Not tested	○ Not Tested

AUDIOLOGY REFERRAL for DIAGNOSTIC TESTING:

Practice/Group Name

Audiologist's Address

City State Zip Code

Audiologist's Phone (☐☐☐) ☐☐☐-☐☐☐☐

Appointment Date: ☐☐/☐☐/☐☐☐☐

Audiologist's Last Name First Name

PLEASE RETURN COMPLETED FORM TO:

Universal Newborn Hearing Screening Program
Maryland State Department of Health and Mental Hygiene
Office for Genetics and Children With Special Health Care Needs
201 W. Preston Street - Room 421A
Baltimore, MD 21201

Top Copy: State Record

Blue Copy: Provider Record

See Back of Blue Copy for Further Instructions

PLEASE MAIL or FAX WITHIN 24 HOURS OF ONE MONTH SCREENING. THE STATE OF MARYLAND, BY LAW, MUST NOTIFY PARENTS AND PEDIATRICIANS OF SCREENING RESULTS. PLEASE HELP US MAKE THIS A MEANINGFUL REPORT TO BOTH THE PARENTS AND PEDIATRICIANS.

HOSPITAL OF BIRTH INSTRUCTIONS: In the 3 spaces provided on the front of the form, please enter the three letter code of the hospital in which the baby was born.

AAG	ANNE ARUNDEL MEDICAL CENTER
BAY	(JOHNS HOPKINS) BAYVIEW MEDICAL CENTER
CAL	CALVERT MEMORIAL HOSPITAL
CCG	CARROLL COUNTY GENERAL HOSPITAL
CIV	CIVISTA MEDICAL CENTER
CUM	MEMORIAL HOSPITAL - WESTERN MD HEALTH SYSTEM
FSH	FRANKLIN SQUARE HOSPITAL
FMH	FREDERICK MEMORIAL HOSPITAL
GAR	GARRETT COUNTY MEMORIAL HOSPITAL
GBM	GREATER BALTIMORE MEDICAL CENTER
HHC	HARBOR HOSPITAL CENTER
HMH	UPPER CHESAPEAKE MEDICAL CENTER
HCH	HOLY CROSS HOSPITAL
HOW	HOWARD COUNTY GENERAL HOSPITAL
JHH	JOHNS HOPKINS HOSPITAL
KQA	CHESTER RIVER HOSPITAL CENTER
GLB	LAUREL REGIONAL HOSPITAL
AND	MALCOLM GROW USAF MEDICAL CENTER
MGH	MARYLAND GENERAL HOSPITAL
MRC	MERCY MEDICAL CENTER
MON	MONTGOMERY GENERAL HOSPITAL
BET	NATIONAL NAVAL MEDICAL CENTER
PEN	PENINSULA REGIONAL MEDICAL CENTER
PGG	PRINCE GEORGE'S HOSPITAL CENTER
SGH	SHADY GROVE ADVENTIST HOSPITAL
EAS	SHORE HEALTH SYSTEM, MEMORIAL HOSPITAL AT EASTON
SIH	SINAI HOSPITAL
SOU	SOUTHERN MARYLAND HOSPITAL CENTER
SAH	ST. AGNES HOSPITAL
SJH	ST. JOSEPH'S HOSPITAL
SMH	ST. MARY'S HOSPITAL
UMH	UNION MEMORIAL HOSPITAL
UCC	UNION HOSPITAL, CECIL COUNTY
UVH	UNIVERSITY OF MARYLAND MEDICAL CENTER
WAH	WASHINGTON ADVENTIST HOSPITAL
WCH	WASHINGTON COUNTY HOSPITAL
MTY	BIRTHING OR MATERNITY CENTER
HOM	AT HOME DELIVERY
OOS	OUT OF STATE

1. How to utilize the level 2: Post Discharge Infant Hearing Screening Form

a. Usage:
   1). Any post-discharge hearing screening
   2.). Including re-screenings due to "Not Pass" or "Not Tested" Status in the hospital.

b. Birth Last Name is the last name of the mother at the time of delivery. Use bubbles to indicate male or female. Indicate multiple births like "Smith A", "Smith B".

c. Fill out completely and neatly, with blue or black ink.

d. Mailing Information is located below.

e. For questions and to order forms, call 410-767-5803 or 1-800-633-1316.

2. Mail Top *White Copy* of this form within 48 hours of testing to:

The Maryland State Department of Health and Mental Hygiene
Office for Genetics and Children with Special Health Care Needs
201 W. Preston Street - Room 421A
Baltimore, MD 21201
OR **Fax to "UNHS" AT 410-333-5047**.

Blue Copy: Provider Record

For your convenience, mailing labels with the above address are available by calling 410-767-5803.

3. Special Notes Box:

Use this area for the Address-O-Graph if applicable or any one or more very brief notes in reference to:

- Previous test results and date
- "Initial Screen"
- Risk factors / gestational age
- Other known diagnosed conditions
- Family's Language spoken if other than English
- "Refused Test", "No show", "Moved Out of state" or "Lost to Follow-up"
- Referral details
- Adoption or foster care information
- Insurance Information