WYOMING EHDI HEARING SCREENING MONTHLY DATA COMPILATION SHEET

For your convenience, the Wyoming EHDI Program has developed this Hearing Screening Monthly Data Compilation Sheet. You may find a paper copy of this form helpful as you gather your monthly hearing screening statistics/information. Below, you will find the questions that comprise the Statistics Questionnaire in the Wyoming EHDI – Information System.

Month: _____ Year: _____

Section 1

1. **Please tell us how many babies were born at your hospital this month?** _____

2. **Of the babies born at your hospital this month, please tell us how many were NOT screened?** _____

If all babies were screened, you may skip the Section 3.

Section 2

Of the babies who were <u>NOT</u> screened:

1. How many were transferred? _____

Please enter the following information for each child transferred:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:
Transfer Hospital: Check one ☐ Benefis Healthcare – Great Falls, MT ☐ Billings Clinic/Deaconess Medical – Billings, MT ☐ Children's Hospital Colorado – Aurora, CO ☐ Eastern Idaho Regional Medical Center – Idaho Falls, ID ☐ Intermountain Medical Center – Murray, UT ☐ LDS Hospital – Salt Lake City, UT ☐ McKay-Dee Hospital Center - Ogden, UT ☐ Out of State – Other ☐ Poudre Valley Hospital – Fort Collins, CO	☐ Presbyterian St. Luke's Medical Center – Denver, CO ☐ Primary Children's Medical Center – Salt Lake City, UT ☐ Rapid City Regional Hospital – Rapid City, SD ☐ Regional West Medical Center – Scottsbluff, NE ☐ St. Mark's Hospital – Salt Lake City, UT ☐ St. Vincent Healthcare – Hardin, MT ☐ U. Of Colorado Health Science Center – Denver, CO ☐ U. of Utah Health Science Center – Salt Lake City, UT ☐ Utah Valley Medical Center – Provo, UT

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Transfer Hospital: Check one

- ☐ Benefis Healthcare – Great Falls, MT
- ☐ Billings Clinic/Deaconess Medical – Billings, MT
- ☐ Children's Hospital Colorado – Aurora, CO
- ☐ Eastern Idaho Regional Medical Center – Idaho Falls, ID
- ☐ Intermountain Medical Center – Murray, UT
- ☐ LDS Hospital – Salt Lake City, UT
- ☐ McKay-Dee Hospital Center - Ogden, UT
- ☐ Out of State – Other
- ☐ Poudre Valley Hospital – Fort Collins, CO
- ☐ Presbyterian St. Luke's Medical Center – Denver, CO
- ☐ Primary Children's Medical Center – Salt Lake City, UT
- ☐ Rapid City Regional Hospital – Rapid City, SD
- ☐ Regional West Medical Center – Scottsbluff, NE
- ☐ St. Mark's Hospital – Salt Lake City, UT
- ☐ St. Vincent Healthcare – Hardin, MT
- ☐ U. Of Colorado Health Science Center – Denver, CO
- ☐ U. of Utah Health Science Center – Salt Lake City, UT
- ☐ Utah Valley Medical Center – Provo, UT

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Transfer Hospital: Check one

- ☐ Benefis Healthcare – Great Falls, MT
- ☐ Billings Clinic/Deaconess Medical – Billings, MT
- ☐ Children's Hospital Colorado – Aurora, CO
- ☐ Eastern Idaho Regional Medical Center – Idaho Falls, ID
- ☐ Intermountain Medical Center – Murray, UT
- ☐ LDS Hospital – Salt Lake City, UT
- ☐ McKay-Dee Hospital Center - Ogden, UT
- ☐ Out of State – Other
- ☐ Poudre Valley Hospital – Fort Collins, CO
- ☐ Presbyterian St. Luke's Medical Center – Denver, CO
- ☐ Primary Children's Medical Center – Salt Lake City, UT
- ☐ Rapid City Regional Hospital – Rapid City, SD
- ☐ Regional West Medical Center – Scottsbluff, NE
- ☐ St. Mark's Hospital – Salt Lake City, UT
- ☐ St. Vincent Healthcare – Hardin, MT
- ☐ U. Of Colorado Health Science Center – Denver, CO
- ☐ U. of Utah Health Science Center – Salt Lake City, UT
- ☐ Utah Valley Medical Center – Provo, UT

2. How many parents/guardians WAIVED the hearing screening for their baby? _____

Please enter the following information for each child with a waived screening:

Last Name:	Reason for Waiving ☐ Financial ☐ Religious ☐ Personal Preference ☐ Unknown ☐ Other: _____
DOB:	
Gender: M F	

Last Name:	Reason for Waiving ☐ Financial ☐ Religious ☐ Personal Preference ☐ Unknown ☐ Other: _____
DOB:	
Gender: M F	

Last Name:	Reason for Waiving ☐ Financial ☐ Religious ☐ Personal Preference ☐ Unknown ☐ Other: _____
DOB:	
Gender: M F	

3. **How many died? _____ Number of Males _____ Number of Females**

4. **How many babies have not yet been discharged (and will be screened prior to discharge)? _____**

5. **How many babies were not screened due to equipment failure? _____**

Please enter the following information for each child not yet receiving a screening due to equipment failure:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

6. How many babies were not screened due to not having screening supplies? _____

Please enter the following information for each child not yet receiving a screening due to not having screening supplies:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

7. How many babies were missed? _____

Please enter the following information for each child not yet receiving a screening due to being missed:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:

8. How many babies were not screened due to other reasons? _____

Please enter the following information for each child not yet receiving a screening due to other reasons:

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:
Reason not screened:	

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:
Reason not screened:	

Last Name:	Mother's First Name:
DOB:	Mother's Last Name:
Gender: M F	Telephone Number:
Reason not screened:	

Section 3

Of the babies who <u>WERE</u> screened:

1. **Have any babies failed their INITIAL screening?** ○ Yes ○ No

2. **Did any of these babies fail their INITIAL screening due to atresia of one or both ears?** ○ Yes ○ No

3. **How many babies failed their initial screening due to atresia of one or both ear?** _____

Babies with atresia are not rescreened but instead are sent directly for a diagnostic evaluation. Who are they?

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	

4. **How many babies who failed their INITIAL screening this month still need to come back for their 7-10 DAY SCREENING?** _____

Please enter the following information for each child with a rescreen pending:

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	Rescreening Appointment Date:

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	Rescreening Appointment Date:

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Telephone Number:
Gender: M F	Rescreening Appointment Date:

5. Have any babies failed their RESCREENING during this month? ○ Yes ○ No

6. How many babies failed their RESCREENING during this month? _____

For each baby who failed their rescreening, please provide the following information:

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Father's First Name:
Gender: M F	Father's Last Name:
Rescreening Appointment Date:	Work Phone:
Home Phone:	Emergency Phone:
Cell Phone:	Message Phone:

First Name:	Mother's First Name:
Last Name:	Mother's Last Name:
DOB:	Father's First Name:
Gender: M F	Father's Last Name:
Rescreening Appointment Date:	Work Phone:
Home Phone:	Emergency Phone:
Cell Phone:	Message Phone:

First Name:	Last Name:
DOB:	Gender: M F
Rescreening Appt. Date:	Home phone:
Cell phone:	Mother's First Name:
Mother's Last Name:	Father's First Name:
Father's Last Name:	Work Phone:
Emergency Phone:	Message Phone:

Section 4

What else do you want us to know?

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