Santé et Services sociaux Québec

DT9271

HEARING SCREENING

Québec Newborn Hearing Screening Program (PQDSN)

Screening center	Date (year, month, day)	Number of weeks of gestation	Age at screening (specify "corrected" if applicable)
		weeks days	

RISK FACTORS FOR HEARING LOSS

☐ **No risk factor(s) for hearing loss identified**

☐ **Risk factor(s) for hearing loss identified:**

- ◯ Family history of hearing loss
- ◯ Congenital TORCH infection
- ◯ Craniofacial anomaly
- ◯ Syndrome associated with hearing loss
- ◯ Hyperbilirubinemia
- ◯ Very low birth weight: < 1,500 g
- ◯ Prematurity: < 29 weeks of gestation
- ◯ Respiratory disorders
- ◯ Neurological disorders
- ◯ Excessive doses of ototoxic drugs

☐ **Risk factor(s) requiring a comprehensive audiological evaluation:**

- ◯ Confirmed bacterial or viral meningitis
- ◯ Anotia, microtia, atresia
- ◯ Extended stay in the neonate ICU (reached the corrected age of 3 months)

HEARING SCREENING TEST RESULTS AND RECOMMENDATIONS

Left ear	☐ Passed	☐ Repeat	☐ Incomplete	**Right ear**	☐ Passed	☐ Repeat	☐ Incomplete

☐ **PASSED SCREENING TEST**

Hearing probably normal.
Progressive or delayed-onset hearing loss cannot be excluded.

☐ **End of PQDSN participation. Age-appropriate parental and medical monitoring of expected auditory and language behaviors remains essential.**

☐ **Risk factor(s) for progressive or late onset hearing loss identified:**

☐ **Referred for audiological surveillance at _____ months (corrected age).**

The parents are responsible to contact their hospital

_____

to schedule an appointment.

☐ **Referred for audiological surveillance at 3 months (corrected age).**

The diagnostic confirmation center:

_____

will contact the parents to schedule an appointment.

☐ **REFERRED FOR OUT-PATIENT SCREENING**

☐ **Expected results not obtained during the stay.** *Possible reasons: temporary (fluid or debris in the ear) or permanent (hearing loss).*

☐ **No screening conducted during the stay.** *The newborn left before the screening test(s) could be conducted.*

◯ Scheduled appointment (screening center)

_____

Date: _____ (Year) _____ (Month) _____ (Day) Time: _____

◯ The screening center will contact the parents to schedule the appointment.

☐ **REFERRED TO THE DIAGNOSTIC CONFIRMATION CENTER**

☐ **Screening failed:** *A comprehensive audiological evaluation is required (does not necessarily mean the baby has a permanent hearing loss).*

☐ **Screening not done:** *Risk factor(s) for hearing loss identified requiring a comprehensive audiological evaluation.*

The diagnostic confirmation center:

_____

will contact the parents to schedule an appointment.

☐ **PQDSN PARTICIPATION ENDED DUE TO:**

☐ Newborn deceased ☐ Parent's withdrawal of consent during the protocol ☐ Newborn under palliative care

Name and signature	Name (in block letters)	Signature