Arizona Early Hearing Detection and Intervention
Arizona Department of Health Services

Medical Home Provider OAE Screening Form

Screener or Contact Name: _____
Screener or Contact Phone:_____
Date Submitted:_____
Practice Name: _____

FAX TO 602-364-1495 within one week of screening

- **Submit for all infants screened up to two years of age, unless child is being screened for otitis media**
- **Submit separate diagnostic report form if diagnostic testing was completed**

Patient Last Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Patient First Name:	Birth Order (if multiple births): ☐ A ☐ B ☐ C ☐ D	
Mother's Full Name:	Birth Facility:	
Mother's Date of Birth:	Date of Screen:	
Primary Care Physician:	Right: ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail
Comments:	☐ OAE ☐ ABR ☐ Behavioral	

Fax to: 602-364-1495 Questions call 602-364-1409

Always start a new log sheet after faxing to ADHS