

Date: \_\_\_\_\_

Dr. \_\_\_\_\_

Baby Name: \_\_\_\_\_

Baby DOB: \_\_\_\_\_



Baby \_\_\_\_\_ needs a second hearing screening after the initial screening using BAER EOAE testing.

The right and/or left ear need(s) to be re-screened.

Please inquire the next time you see the family if they have returned for a follow-up screening or have an appointment for one. If not, please encourage them to call **(your UNHS program contact info)** to schedule an appointment.

-Thank You-

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### WAA XASUUSIN KALIYA ...

Ubadkaada wuxuu u baahan yahay inaa ku sameeyso dabagal baarista maqalka 30 bari gudahooda.

Fadlan soo wac **(Your UNHS program contact info)** u sameeynta jadwalka balanka ama ka jawaabida su'aaladahaada.

**Your hospital's name, logo  
and address here**