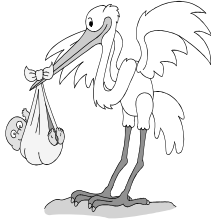


Date: \_\_\_\_\_

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-



**JUST A REMINDER...**

Your baby needs to return for a follow-up hearing screening within 30 days.

Please call **(Your UNHS program contact info)** to schedule an appointment or to answer any questions.

Your hospital's name, logo  
and address here