

Universal Newborn Hearing Screening and Intervention Act of 2009

Manual of Operations of RA 9709



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MALACAÑAN PALACE
MANILA

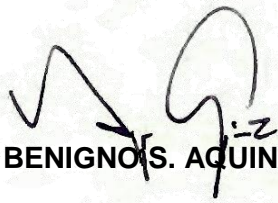
MESSAGE



My warmest greetings to the **Philippine National Ear Institute**, on the publication of your **Manual of Operations** for the **Universal Newborn Hearing Screening Program**. Let me also acknowledge the **Department of Health** for your role on the crafting of the publication.

The success of our development agenda rests on the enthusiasm, resolve, and well-being of our people, and it is your government's mission to elevate the quality of their lives. Our citizenry's welfare can be secured at the earliest possible moment through newborn screening, which can prevent the onset of any disease that may deprive a child of the chance to achieve his fullest potential. This Manual is an important step towards our drive to mitigate hearing loss and impairment among newborns. It is my hope that our professionals in this sector will make full use of this publication to advance their practice and improve the overall state of medical care in the country.

One of the core objectives of my administration is to ensure that every Filipino receives ample medical attention, through the implementation of Universal Health Care. In this and other vital pursuits towards nation-building, let us demonstrate passion, excellence, and integrity, as our actions will be instrumental in empowering our citizenry, the ultimate catalysts in our goal of lasting, equitable progress.



BENIGNO S. AQUINO III

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY



M E S S A G E

The Department of Health (DOH) commends the **Philippine National Ear Institute of the National Institutes of Health-University of the Philippines Manila** on its initiative to develop the *Manual of Operations (MOP)* for the Newborn Hearing Screening Program.


The benefit of administering newborn screening for deafness cannot be overemphasized. Early identification and interventions can prevent severe psychosocial, educational, and linguistic repercussions. Infants who are not identified before 6 months of age incur delays in speech and language development. This necessitated the imperative action to institutionalize a program for screening.

The passage of the Universal Newborn Screening Hearing and Intervention Act of 2009 put the focus on the prevention and early diagnosis of congenital hearing among newborns. The designation of the U.P. National Institutes for Health as the Newborn Hearing Screening Reference Center established the Central facility to define testing and referral protocols, to maintain the external laboratory proficiency testing program, to oversee the national testing database and case registries, to assist in training activities and to oversee the content of information materials. This being a national program that needs to be implemented down at the local level clearly mandated the drafting of a Manual of Operations to be adopted by the to-be-designated Newborn Hearing Screening Centers.

At this juncture, we reaffirm the Department of Health's commitment to be the lead agency in implementing this Act. With everyone's support, we know that the full implementation of this Program will be realized.

Onwards to Kalusugan Pangakalahatan!

Congratulations and Mabuhay!


Enrique T. Ona, MD
Secretary of Health



**UNIVERSITY OF THE PHILIPPINES
Quezon City
OFFICE OF THE PRESIDENT**

M E S S A G E



Isang mapagpala't mapagpalayang araw sa inyong lahat!

I congratulate the National Institutes of Health of UP Manila for the creation of this Manual of Operations (MOP) for the Newborn Hearing Screening Program (NHSP). For more than a decade, UP Manila through the Philippine National Ear Institute has been a tireless partner of the people by providing cutting-edge research on hearing and balance. You have attained an enviable status as one of the country's most dedicated and innovative leaders in health research and care.

True to the University's mission of shaping minds that shape the nation, your research works have aided not only in the promotion of awareness on hearing issues, but have influenced also policy-making in the country. These feats truly reflect UP's vision as being a university where strong research is employed in solving our country's problems.

May this Manual of Operations, finalized in cooperation with the Department of Health, be instrumental in ensuring that newborn children in this country are protected from hearing loss through effective screening and care. The guidance this manual provides will mean the true spirit of Republic Act (RA) No. 9709 (An Act Establishing a Newborn Screening Program for the Prevention, Early Diagnosis and Intervention of Hearing Loss) will be felt by families all over the country. Let us work to ensure that our children will not be deprived of their right to full and healthy development as individuals, as well as their right to a better quality of life.

I pledge the support of my administration to both the UP Manila National Institutes of Health and the Newborn Hearing Screening Reference Center. May the efforts of everyone involved – from specialists and researchers to educators and staff – result in meeting the objectives of RA 9709. This manual makes me very optimistic that the protocols, expertise and organization required to make this goal a reality will be attained.

In line with UP Manila's mission to be not only an outstanding but also a relevant institution of higher learning, let us use our resources to ensure that the interests of our country's youth are given priority. May these efforts result in a future where no child is deprived of his or her hearing needlessly and where they are given every opportunity to be productive members of society. Let us do the best for our country's children!

Mabuhay ang NHSRC! Mabuhay ang UP Manila! Mabuhay ang Unibersidad ng Pilipinas!

ALFREDO E. PASCUAL
President



University of the Philippines Manila
The Health Sciences Center
Office of the Chancellor



MESSAGE

After newborn screening, UP Manila rejoices in another milestone program that addresses another pressing health problem in Filipino newborns.

The enactment of Republic Act 9709, or the Act that establishes the Universal Newborn Hearing Screening for the Prevention, Early Diagnosis and Intervention of Hearing Loss in August 2009 institutionalizes the urgent need for newborn hearing screening and emphasizes the importance of early identification and intervention.

I am so happy and proud that this law was passed and approved based on the findings of the researches conducted by our very own Philippine National Ear Institute under the National Institutes of Health. This is exactly what I mean by my entrepreneurial research thrust – conducting relevant researches with policy impact that can be translated into national policies and eventually into concrete programs that help address major health problems affecting the people.

It has almost been three years since the enactment of Republic Act 9709 and it is time for the law to be implemented in accordance with its intents and goals. To be able to do this, however, implementing guidelines have to be prepared and protocols and procedures for screening and other tasks have to be in place.

This Manual of Operations fills that purpose. It serves as a comprehensive guide and reference material for service providers and health workers who are engaged in the provision of newborn hearing screening, be it actual screening, training of health workers, or application of intervention strategies. The roles and responsibilities of each service provider are, likewise, outlined in the MOP for a clearer delineation and discharge of functions.

I commend behind those behind the preparation of this Manual. Your painstaking work and finalization of this material ensures the hurdling of one vital step towards the successful realization of the program. More challenges are coming but with the concerted efforts of the concerned institutions, health providers, other stakeholders and the public, there is no reason why Filipino children cannot enjoy a good life and future even with hearing impairment.

MANUEL B. AGULTO, MD
Chancellor

PREFACE

In an effort to emphasize the importance of early detection and intervention for infants with hearing loss, the National Institutes of Health (NIH) and the Philippine National Ear Institute (PNEI) played very important roles in fulfilling this commitment. Numerous research studies were conducted which determined the need for appropriate intervention and provision of hearing screening access among newborns across the country.

The formation of the Task Force on Newborn Hearing Screening in 2007 was the first step towards addressing this pressing concern on how to prevent the repercussions of hearing impairment through early identification and intervention. Although advocacy programs, lectures and conferences were continuously carried out, in 2008 the task force took that bold initiative to push for legislative efforts through Senator Loren Legarda.

The Republic Act 9709 also known as An Act Establishing a Universal Newborn Hearing Screening Program for the Prevention, Early Diagnosis and Intervention of Hearing Loss was finally approved and signed into law on June 2009. The enactment of RA 9709 mandates all newborns to undergo hearing screening prior to hospital discharge or within three months after birth.

This Manual of Operations (MOP) was carefully drafted and developed to implement a comprehensive program that would meet the objectives of RA 9709 – prevention, early detection and diagnosis of congenital hearing loss among newborns and infants. The scope of the manual includes UNHS protocols and procedures in both hospital-based and community-based settings. Respective roles of each service provider, be it private or public, are also relayed in detail to ensure that screening methods are precisely carried out.

PNEI would like to express its sincerest gratitude to all individuals and institutions who have given their contributions to complete this manual.

Figure 1 NHS System Framework

Table 1 Stop Criteria for Well Baby OAE and High Risk Baby <5 days old

Table 2 Stop Criteria for OAE Outpatient Screening (per ear)

Appendix A	Republic Act 9709
Appendix B	Administrative Order No. 2010-0020
Appendix C	Philhealth Circular No. 011-2011
Appendix D	Refusal Form English
Appendix E	Refusal Form Filipino
Appendix F	UNHS High Risk Questionnaires For Community-Based Facilities Level 1 Questionnaire
Appendix G	UNHS High Risk Questionnaires For Community-Based Facilities Level 2 Questionnaire
Appendix H	Department of Health Classification of Hospitals and Other Health Facilities
Appendix I	Risk Indicators Associated With Permanent Congenital, Delayed-Onset, or Progressive Hearing Loss in Childhood
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Appendix Q	Sample of Newborn Hearing Screening Official Result
Appendix R	Sample of Newborn Hearing Screening Brochure
Appendix S	Sample of Newborn Hearing Screening Brochure
Appendix T	Newborn Hearing Screening Registry Form
Appendix U	Application Form for Newborn Hearing Screening Center Personnel
Appendix V	Application Form for Newborn Hearing Screening Center

ACRONYMS

AABR	Automated Auditory Brainstem Response
ASSR	Auditory Steady State Response
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
BHW	Barangay Health Worker
CHO	City Health Office
CoNHScA	Collaboration on Newborn Hearing Screening Advocacy
DOH	Department of Health
DPOAE	Distortion Product Otoacoustic Emissions
DSHS	Department of State Health Services
ECCD	Early Childhood and Care Development
ENT	Ear, Nose and Throat
FDA	Food and Drug Administration
HI	Hearing Impairment
LGU	Local Government Unit
MHO	Municipal Health Office
NHS	Newborn Hearing Screening
NHSC	Newborn Hearing Screening Center
NHSP	Newborn Hearing Screening Personnel
NHSRC	Newborn Hearing Screening Reference Center
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NTC	National Telecommunications Commission
NSC	Newborn Screening Center
OAE	Otoacoustic Emissions
PANORS	Philippine Academy of Neurotology, Otology and Related Sciences
PCA	Post Conceptional Age
PCSO	Philippine Charity Sweepstakes Office
PSO-HNS	Philippine Society of Otolaryngology Head & Neck Surgery
QOL	Quality of Life
RA	Republic Act
RHU	Rural Health Unit
SNR	Signal to Noise Ratio
TBA	Traditional Birth Attendant
TEOAE	Transient Evoked Otoacoustic Emissions
UNHS	Universal Newborn Hearing Screening
UNHSP	Universal Newborn Hearing Screening Program

ACKNOWLEDGEMENT

Senator Loren Legarda

Congressman Arthur Y. Pingoy, MD 2nd District, South Cotabato

Congressman Narciso D. Santiago III, (Partylist- ARC)

Esperanza Cabral, MD, Former DOH Secretary

Ramon Arcadio, MD, Former UP Manila Chancellor

Perla Santos-Ocampo, MD, National Scientist and Former UP Manila Chancellor

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INTRODUCTION

A. Brief History of Universal Newborn Hearing Screening in the Philippines

Hearing loss is known to be one of the most common disabilities among newborns. Prevalence studies worldwide revealed that approximately 1-4 infants per 1,000 live births are affected.^{1,2,3,4,5} Hearing is necessary in speech development as well as mental growth. Early detection of hearing loss and intervention is crucial in addressing this disability.^{6,7,8} With this information at hand, the Philippine National Ear Institute (PNEI) initiated research in newborn hearing screening since the year 2000.^{9,10} In a study conducted in a rural population in Bulacan in 2004, it has been revealed that 1 per 724 babies are born with bilateral severe to profound hearing loss, thus, 0.14% or 8 babies born daily are estimated to have profound deafness in our country alone.⁸

In 2007, a Task Force on Newborn Hearing Screening was convened by PSO-HNS with the PNEI working group, which rigorously researched, analyzed and considered the benefits of the Universal Newborn Hearing Screening Program (UNHSP) for further recommendation and implementation. It was in the same year that the first annual Collaboration on Newborn Hearing Screening Advocacy (CoNHScA) was held, where activities, practices and experiences of the UNHSP in various communities were conveyed.

With the numerous endorsements and advocacy programs that were put forward to emphasize the importance of early detection and intervention for infants through UNHS, subsequent legislative efforts played an important role by emphasizing the need for the appropriate intervention and providing hearing screening access across the nation. It was in January 2008 when Senator Loren Legarda was informed of PNEI studies related to UNHS as well as the Task Force Efforts and the 2007 Position Paper. Support from the Department of Health, headed by the former Secretary, Francisco T. Duque, III was later sought through a meeting with PSO-HNS and PANORS in May 2008.

The Senate Bill No. 2390 or the Universal Newborn Hearing Screening and Intervention Act of 2008 was officially filed and submitted on June 10, 2008 by its authors, Senators Miriam Defensor Santiago, Loren B. Legarda and Pia S. Cayetano.

Almost exactly a year after, the Conference Committee Report recommending that SBN-2390 consolidated with HBN-2677 were approved by the Senate and the House of Representatives. Consequently, enrolled copies of the consolidated version of SBN-2390 and HBN-2677, sponsored by Congressmen Narciso D. Santiago III and Arthur Y. Pingoy, Jr. and signed by the Speaker and Secretary General of the House of Representatives were received by the Senate and were sent to the Office of the President of the Philippines for signature and approval.

In June 12, 2009, Republic Act 9709 also known as the Universal Newborn Hearing Screening and Intervention Act was approved and signed into law by the President of the Philippines, Gloria Macapagal Arroyo (Appendix A). RA 9709 establishes a UNHS program for the prevention, early diagnosis and early intervention of hearing loss and requiring all newborns to have access to hearing screening. With this successful ratification, the drafting of the Law's Implementing Rules and Guidelines was done under the supervision of former Health Secretary - Esperanza Cabral and close collation with PNEI and other stakeholders. In June 28, 2010, IRR of RA 9709 was approved, signed and disseminated as Administrative Order 2010-0020 (Appendix B).

Philhealth circular No. 011-2011 was signed by the President and CEO of Philhealth, Dr. Rey B. Aquino on August 5, 2011 (Appendix C). The mechanism for Philhealth claims was stated in this circular.

B. UNHS Milestones

2007	Task Force on Newborn Hearing Screening convened by PSO-NS with PNEI working group First annual Collaboration on Newborn Hearing Screening Advocacy (CoNHScA)
January 2008	PNEI studies related to UNHS, PSO-HNS Task efforts and Position Paper forwarded to Senator Loren Legarda
April 2008	Technical working group convened by the senate for UNHS Program legislation

May 2008	PSO-HNS meeting with DOH Secretary Francisco Q. Duque to reiterate support for UNHS Program legislative efforts
June 10, 2008	Prepared and submitted jointly by the Committee(s) on Health and Demography and Finance with Senator(s) Miriam Defensor Santiago, Loren B. Legarda and Pia S. Cayetano as author(s) per Committee Report No. 71, recommending its approval in substitution of SBNOs. 1209 and 1372
October 2, 2008	Senate Bill forwarded to the House of Representatives
June 2009	Bicameral approval
July 15, 2009	SBN-2390 and HBN-2677 sent to the Office of the President of the Philippines for signature and approval
August 12, 2009	RA 9709 approved and signed into law by the President of the Philippines, Gloria Macapagal Arroyo
June 28, 2010	RA 9709 Implementing Rules and Regulations approved and signed by then DOH Secretary Esperanza Cabral as Administrative Order 2010-0020
December 2010	Drafting of the Manual of Operations with the Department of Health
August 05, 2011	Philhealth issues Circular 011-2011 indicating that Newborn Hearing Screening is included in the Newborn Care Package

C. Vision, Mission, Goals and Strategic Directions

Vision

“No Filipino newborn shall be deprived of a functional sense of hearing.”

Every newborn shall be given access to physiologic hearing screening examination prior to hospital discharge or at the earliest feasible time for the detection of hearing loss.

Mission

- To have all newborns undergo hearing screening prior to hospital discharge or within three months if born outside the hospital;
- To provide an accessible, effective and efficient system of services;
- To implement time-bound intervention: hearing screening within the first month, hearing evaluation within the third month and early intervention by the sixth month;
- To provide the necessary services for hearing habilitation/rehabilitation;
- To monitor the incidence and prevalence of hearing loss in the Philippines;
- To promote awareness and information campaign to the public about hearing loss.

Goals

- To implement an effective system to have all newborns undergo hearing screening and increase the proportion of infants who are screened for hearing loss within their first month of life;
- To identify hearing loss through audiologic evaluation among infants within three months of age;
- To implement early intervention services among infants diagnosed with hearing loss within six months of age.

Strategic Directions

- Identify standards and policies for hearing screening and follow-up
- Determine effective ways of implementing standards and policies
- Collaborate with families, local government units, hospitals, health centers and other stakeholders
- Acquire financial and funding support from government agencies and non-government organizations
- Educate and disseminate information among key stakeholders (e.g. trainings, media)
- Monitor, track and evaluate hearing screening data to generate research, formulate policies and improve the program
- Generate ways to improve accuracy and quality of hearing screening data
- Devise a sustainable system for the program

D. Universal Newborn Hearing Screening (UNHS) System Framework

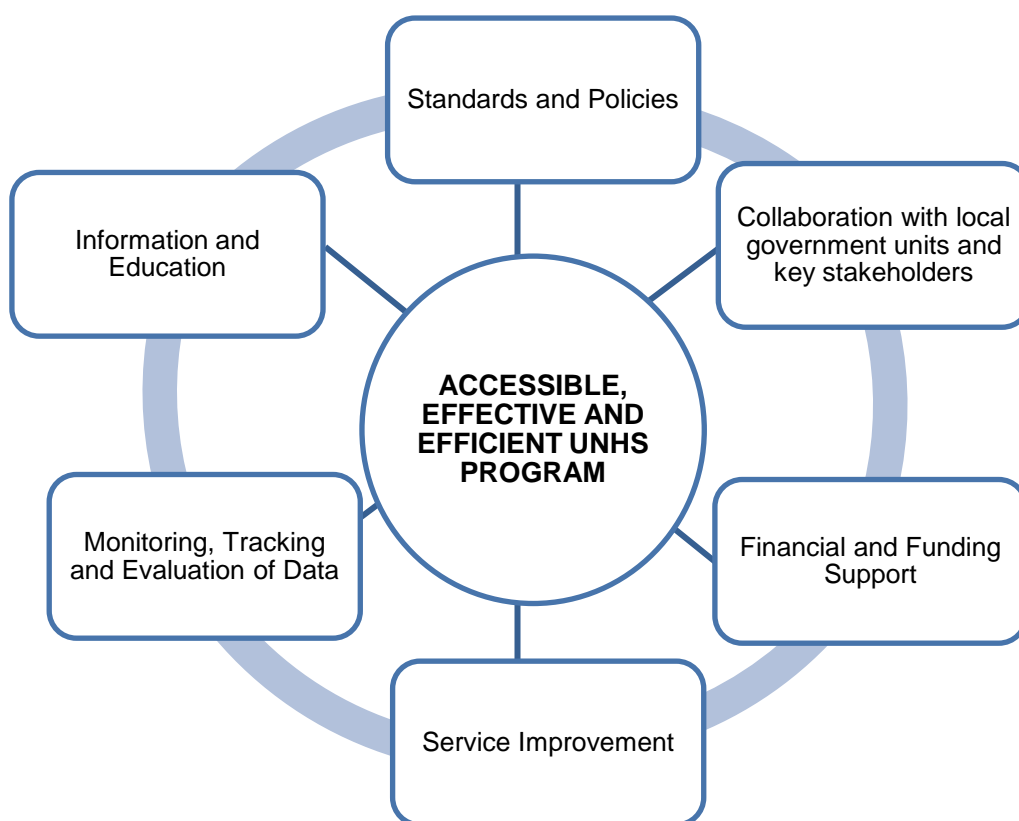


Figure 1. UNHS System Framework

I. OVERVIEW

A. Who are qualified to be screened?

In accordance with international clinical practice guidelines and provision in Republic Act 9709, ***all newborns in the Philippines, with the consent of the parent/s or guardian*** should be subjected to universal hearing screening. Consent forms are not necessary. However, a refusal form (Appendix D and E) is necessary if the parent or guardian does not want the infant subjected to hearing screening. All infants identified with hearing loss should have access to resources necessary to reach their maximum potential.

B. When is the right time to screen?

The right time to screen is **on or after (\geq) 24 hours after birth**, before the infant is discharged if hospital born. If the infant is out-of-hospital born then he or she should be screened **not more than (\leq) 3 months of age**, regardless where they are delivered (includes infants who were hospital born but hearing screening was not done before discharge). For purposes of **PhilHealth reimbursement, babies must be screened within (\leq) 2 months (60 days) of age**.

Hearing screening done in a hospital or birthing facility is performed as close to discharge as possible to give time for the passage of amniotic fluid or vernix from the external auditory canal. For those babies who received medical treatment, the test should be conducted only after the baby is perceived well.

C. Where to avail of Newborn Hearing Screening?

The **Department of Health** in collaboration with the National Institutes of Health Philippines shall **categorize, license and certify Newborn Hearing Screening Centers** where the newborn hearing screening tests can be done.

D. Who can perform the Newborn Hearing Screening Test?

Qualified **adult (\geq 19 years old)** personnel who may perform the newborn hearing screening may include audiometrists, audiologists, licensed health professionals such as medical technologists, physicians, nurses, midwives and trained health workers like nursing attendants and barangay health workers. Individuals who would like to be able to perform the standard procedures must be certified in a DOH-NIH training program as prescribed in Section 11, RA 9709 and IRR Rule 5 Section 21.

E. What methods can be used in Newborn Hearing Screening?

Currently acceptable universal screening methods are otoacoustic emissions (OAE) and automated auditory brainstem response (AABR). If OAE and AABR are not available in the vicinity of the place of birth despite **full cooperation and effort of the parents/guardians**, DOH and NHSRC approved alternative methods may be performed by health workers trained on the alternative method employed. Such alternative methods include the World Health Organization questionnaires¹⁴ (Appendices F and G) and the Reflexive “Baah” Test.¹¹ Technologies and methods may change and will be updated periodically, every three (3) years by the DOH and NHSRC.

II. CLASSIFICATION OF PATIENTS

All newborns, whether hospital born, out of hospital born, high risk, non-high risk or re-admitted, must undergo newborn hearing screening, as described in the Section 6, RA 9709.

A. Facility Born Babies: Babies who are born in the hospital and other health facilities such as basic emergency obstetric and newborn care (BEmONC)-capable facilities, maternity lying-in clinics, rural health units (RHUs), barangay health stations (BHS), birthing facilities, private midwives clinics and other facilities as determined by DOH (Appendix H).

B. Home Born Babies: Babies delivered at home, whether or not the birth was attended by a midwife, nurse or physician.

C. High Risk Babies: Babies who have one or more of the high risk factors for hearing loss (Appendix I). These babies require closer monitoring even if they “pass” during the initial testing stage because of the possibility of late-onset or progressive hearing loss.

D. Non-High Risk Babies: Babies who do not have any of the high-risk factors. The parents/caregivers of these babies have to be informed of the normal hearing milestones, to watch for the normal development of speech and language and to consult their physicians for any concerns.

III. PROCEDURES, STANDARDS AND PROTOCOLS

A. NEWBORN HEARING SCREENING METHODS

Currently Acceptable Standard Newborn Hearing Screening Methods

1. *Automated Auditory Brainstem Response (AABR)*

Sounds are played to the baby's ears after electrodes are placed on the baby's head to detect responses. This screening measures how the hearing nerve responds to sounds and can identify babies who have a hearing loss.

2. Otoacoustic Emissions (OAE)

A miniature earphone and microphone are placed in the ear. Sounds are played and a response is measured. If the ear reacts, a response can be measured in the ear canal by the microphone. When a baby has a hearing loss, no response can be measured on the OAE test. The two types of OAE screenings are:

- a. *Transient Evoked Otoacoustic Emissions (TEOAE)*
Sounds emitted in response to an acoustic stimulus of very short duration; usually clicks but can be tone-bursts.
- b. *Distortion Product Otoacoustic Emissions (DPOAE)*
Sounds emitted in response to two simultaneous tones of different frequencies.

Alternative methods, instruments and procedures

Every effort should be made to provide objective hearing screening tests, as mentioned above, to the newborn. Validated DOH and NHSRC approved alternative methods may be used as community based hearing screening tests in the absence of OAE and AABR for initial screening. Using these alternative methods may increase the number of babies being screened because it will be more accessible, based on the studies of Garcia et al 2012¹¹ and by Abes, FL and Gloria-Cruz, 2012. However, other methods maybe developed in the future which can further improve accessibility to more valid testing. A fee cannot be charged to those who will undergo screening using alternative methods.

B. CURRENTLY APPROVED NEWBORN HEARING SCREENING DEVICES

The NHSRC shall recommend technologies and equipment that are registered at the Food and Drug Authority (FDA). Applications forms (Appendix J) for device certification shall be made available online at the NIH, NHSRC and DOH websites.

Devices should have a well-defined and detailed warranty specification for hardware and software (if applicable) servicing and support for the duration of the certification. It should be calibrated in accordance with the manufacturer's recommendation and a log should be kept documenting the dates of calibration, repair or replacement of parts.

Devices should have a local distributor with a nationwide coverage.

Devices should be able to display and print out screening results either directly or indirectly (thermal paper, inkjet printer, laser printer or capture and print-out LCD or computer monitor display) the name, date, time and result of test (Pass/Refer) for each ear.

The specific minimum device specifications for currently acceptable technologies are as follows:

1. *Distortion Product Otoacoustic Emissions (DPOAE)*

Stimulus type: 2 primary puretones; stimulus measured at $2f_1$ -fs

Stimulus intensity (dB SPL) (L1/L2): 65/55 or 60/50

Frequency ratio (f_2/f_1): 1.22-1.24

F2 frequency region: 2-5 kHz; 1-6 kHz; 2-6 kHz; 1.5-12 kHz

Pass Protocol: response from 3 out of 4 frequencies

2. *Transient Evoked Otoacoustic Emissions (TEOAE)*

Stimulus type: click

Click rate: 50-80 per second

Stimulus Intensity: 70-84 dB SPL

Frequency region: 1-5 kHz; 1.5-4.5 kHz; 2-6 kHz; 0.7-4 kHz

Pass Protocol: Presence of a response as an SNR of at least 3-6 dB, or an overall minimum amplitude (wideband) response of 6 dB, with a reproducibility of 50% or greater

3. *Automated Auditory Brainstem Response (AABR)*

Stimulus: click

Click type: 0.1 msec

Stimulus polarity: rarefaction, condensation or alternating

Sweep rate (clicks/sec: within 32-62

Input frequency range: within 30-3,000 Hz

Stimulus intensity: 35 dB

Pass Criteria: Automated

C. PROTOCOLS

The newborn hearing screening protocols should be in accordance to the classification of the patient and availability of hearing screening devices or methods. Refer to Appendices K, L and M for the recommended newborn hearing screening algorithms. These algorithms may be changed every **three (3) years** depending on best available evidence.

This is the summary of current, acceptable, appropriate hearing screening procedures that can be done in a health care facility according to its capability as determined by the DOH.

1. For health facilities without OAE or AABR and without health professionals, but with trained health workers

- Screening using the Reflexive Behavioral Test (voice or “Baah” Test)
Sound is presented 1-2 feet away from the ear. The result is “PASS” if heard, “REFER” if otherwise.
- Level 1 Questionnaire is filled-out by the parent or guardian (Appendix D).

2. For health facilities without OAE or AABR and with health professionals

- Screening using the Reflexive Behavioral Test (voice or “BAAH” Test)
- Use Infant Milestones Related to Hearing as checklist (Appendix N)
- Level 2 Questionnaire is filled-out by the attending doctor or midwife (Appendix G).

3. For health facilities with OAE and AABR and with health professionals or trained health workers

- OAE or AABR

The referring health care professional should be informed by the facility of the results and its implications and suggest the necessary follow-up tests.

D. STOP CRITERIA DURING SCREENING SESSIONS

Stop criteria defines the conditions under which no further screening test is needed.

1. *Stop Criteria for Well Baby (Non-High Risk) using OAE*

Assuming that screening conditions are adequate (quiet baby, quiet room, acceptable probe fit):

- OAE screening in the well-baby, roomed-in with mother
- Two (2) screening sessions of no more than three (3) screens per ear are recommended, for a total of a maximum six (6) screens per ear. The screening sessions should be conducted several hours apart.
- If result of the first test of the first session is “PASS” then the patient is declared “PASS” for that ear. There is no need for a second session.
- If the result of the first test of the first session is “REFER” then, 2 more tests can be done for that session. If the results of the three tests are “REFER” then a second session is conducted at least 2 hours later.
- A baby who had a “REFER” result on OAE should not be rescreened with AABR but rather should proceed to a diagnostic ABR and/or - ASSR.

2. *Stop Criteria for High Risk Infants using OAE*

Assuming that the screen conditions are adequate (quiet baby with minimal movement, quiet room, acceptable electrode impedance and headphone placement):

- Baby should be screened close to the time of discharge.
- If the baby is less than five (< 5) days old, follow the well-baby protocol.
- If the baby is at least five (\geq 5) days of age, recommended stop criteria are one (1) screen per ear.
- A baby who had a “REFER” result on OAE should not be rescreened with AABR but rather should proceed to a diagnostic ABR and/or ASSR.

Table 1: Stop Criteria for Well Baby OAE and High Risk Baby <5 days old

SESSION TRIAL	FIRST SESSION			SECOND SESSION			READING
	1 st	2 nd	3 rd	1 st	2 nd	3 rd	
POSSIBLE RESULTS	Pass						PASS
	Refer	Pass					PASS
	Refer	Refer	Pass				PASS
	Refer	Refer	Refer				2 ND SESSION*
				Pass			PASS
				Refer	Pass		PASS
				Refer	Refer	Pass	PASS
				Refer	Refer	Refer	REFER**

* 2nd session with an interval of at least 2 hours from 1st session

** Proceed to diagnostic ABR / ASSR

See Appendix O for the stop criteria algorithm for well baby OAE and high risk baby <5 days old.

3. Stop Criteria for all infants using Automated Auditory Brainstem Response (AABR)

- Maximum of two (2) screens per ear

E. FOLLOW-UP TESTING AND MANAGEMENT FOR “REFER” RESULTS

Please follow flowcharts for the Newborn Hearing Screening Program (Appendices K, L and M). These are the key points in the algorithm:

1. Follow-up testing must be done within one to three (1–3) months. Rescreening of infants should include re-evaluation of both ears even if only one (1) ear failed at initial screen.
 - a. For OAE outpatient rescreening, 3 screening per ear is recommended (Table 2).
 - b. For AABR outpatient rescreening, one screen per ear is recommended.

Table 2: Stop Criteria for OAE Outpatient Screening (per ear)

TRIAL					READING
	1 st	2 nd	3 rd	4 th	
	Pass				Pass
	Refer	Pass			Pass
	Refer	Refer	Pass	Pass*	Pass
	Refer	Refer	Pass	Refer	Refer
	Refer	Refer	Refer		Refer

* If the infant has a “Pass” result on the third trial; another trial must be done. If the result of the fourth trial is a “Pass” then the final result is a “Pass”, if the result is a “Refer” then the final result is a “Refer”.

See Appendix P for the stop criteria algorithm for OAE outpatient screening.

2. Formal auditory brainstem response, auditory steady state response (ASSR), and/or behavioral audiometric tests (if available) are recommended for infants who do not pass 2nd screening within three (3) months.
3. All infants with identified hearing loss should be referred by the primary health care professional to a board-certified ENT specialist within six (6) months after detection of hearing impairment for further management by a multidisciplinary team. The same primary health care professional should refer to other specialists and other professionals for continuing care.
4. Intervention in the form of hearing aid fitting, hearing and behavioral rehabilitation must be recommended within 6 -12 months after consult with an ENT specialist.
5. The health care professional who is providing primary care services to the infant is responsible for ensuring access to a team of professionals in multiple disciplines for habilitation and management.

F. SCREENING ENVIRONMENT

The NHSC must ensure that the screening environment is consistent with technical standards set by the NHSRC. There should be minimal noise, ≤ 40 dB. Hearing screening may be done in a designated room or at bedside. Acoustic dividers or curtains should be present. Radio, cell phones, TV and other audio devices must be turned off. Tests shall be done after nursing or feeding and away from other babies. Screening rooms shall always be available during screening times.

G. DECONTAMINATION OR DISINFECTION TECHNIQUES

The NHSP must ensure that all hearing equipment and methods are maintained according to infection control guidelines as prescribed by the DOH and the Philippine Hospital Infection Control Society (PHICS) and other infection control societies.

H. CONVEYING TEST RESULTS AND INFORMATION TO FAMILY

Screening results should be conveyed immediately to the parent/s or guardian so they understand the outcome and the importance of follow-up when indicated. The official result of the screening test (OAE or AABR) should be printed on thermal paper or captured using camera or scanner indicating the date and time of acquisition. Appendix Q shows an example of the hearing screening official result. The official result is not the same as the Newborn Hearing Screening Registry Form. There is no reader for OAE and AABR as the results are automated. Hence, no reader's fee can be charged for OAE and AABR. The certified newborn hearing screener should sign the official result of the OAE or AABR.

Conveying test results shall be part of the Certifying Training Program. To facilitate this process for families, hearing screening personnel should ensure the following:

- Communications with immediate family members (parent/s or guardians) are **confidential** and presented in a caring and sensitive manner, preferably face-to-face.
- Medical professionals, specifically the Head of the Hearing Screening Center, primary care giver, physician or pediatrician of the child should also be aware of the results of the screening test and are documented in the hospital medical record.
- Before discharge, parents should be offered an appointment for follow-up testing if the newborn has a "REFER" result.
- The Head of the Hearing Screening Center is primarily accountable for the accuracy of the results and the reporting of the same to the parents or guardians, primary care physician or pediatrician, hospital/health facility and NHSRC.
- The NHS Center and Personnel has the responsibility of providing educational materials based on DOH and NHSRC recommendations. Educational materials should provide accurate information at an appropriate reading level and in a language or dialect they are able to comprehend. Appendices R and S shows an example of such brochures. Materials should include a list of rehabilitation services,

diagnostic and therapeutic facilities, hospitals, schools, therapy centers and support groups in the locality. NHS Centers and Personnel are encouraged to submit materials to the DOH and NHSRC for approval and cataloging prior to posting and/or distribution.

- For “REFER” results, the NHSP are required to give a written referral to a specific service provider for further management.
- The NHSP are required to follow-up and document all high risk patients.
- It is expected that most of the results of screening would be “PASS” for both ears. However, it should be emphasized that hearing loss may have a delayed onset and that milestones related to hearing should be observed in the infant (Appendix N).

I. REGISTRY FORM AND REPORTING OF RESULTS

Proper recording, reporting and archiving of newborn hearing screening data shall be instituted in all participating health facilities. Reports using the required format must be submitted to NHSRC monthly, on or before the 7th day of the succeeding month. Methods of reporting and data encoding shall be part of the Category A Newborn Hearing Screening Certifying Course and Orientation to RA 9709 Courses.

An infant shall be assigned a Newborn Hearing Screening Registry Card (Appendix T) from the NHSRC which bears a unique alphanumeric code and a tablet or camera readable QR code. The parent shall keep the white copy with the QR code which contains UV fibers and watermark logo of the NHSRC as security features. The yellow copy shall be archived by the NHS center within the facility where the child was born for a period of at least three (3) years. The blue copy shall be attached to the Philhealth claim as proof of service. The NHS Registry Form contains the following information:

General Data

Patient's Code
 Name of Infant (Last, First, Middle)
 Date and Time of Birth
 Infant's Gender
 Birthing Facility Name and Complete Address
 Birthing Facility Code to be given by DOH (includes all hospitals and lying-in centers, home births will also be given a unified code number)
 Infant's Medical Record Number in the Birthing Facility*
 Mother's Name (Last, First, Middle)
 Mother's Medical Record Number in the Birthing Facility*
 Mother's Complete Address
 Mother's Telephone Number

Name and Complete Address of Infant's Health Professional (Physician or midwife) or Clinic (Physician or Clinic that will undertake the care of the baby following discharge)*

** data may not be available*

Screening Data

Type of Screening: Initial or Rescreen

Date of Screening

Screening Facility Name and Complete Address

Screening Facility Code to be given by DOH

(includes all hospitals, clinics and health centers with capacity to screen)

Birth weight (in grams)

Gestation Age (in weeks)

Risk Factors for Hearing Loss

Neonatal indicators:

Hyperbilirubinemia requiring transfusion

Ventilation >48 hrs

Illness or condition requiring NICU >48 hrs

Ototoxic medications

Features or other findings associated with a syndrome known to include hearing loss

Family history of permanent childhood hearing loss

Craniofacial anomalies including those with morphological abnormalities of the pinna and ear canal

In-utero infections such as CMV, herpes, toxoplasmosis, syphilis or rubella

Method of Screening (OAE or AABR)

Results: Right: Pass or Refer

Left: Pass or Refer

Others: Not performed, Declined, Discharged

Verifier Data

Complete Name

License Number (if applicable)

Signature of Verifier

(may be physician, audiologist, nurse, midwife or health worker who has been officially designated by the screening facility)

Test results and certain statistics such as total births and refusals must be encoded in the prescribed method (website, tablet application, etc.) taught during the Category A Newborn Hearing Certifying Course. All pertinent information of the patients screened during the previous month must be submitted by the centers on or before the 7th day of the succeeding month. The registry forms and the official results of the OAE or AABR with the thermal paper or photo print-out showing the date and time (Appendix Q) of the test should be scanned and stored electronically for quality control purposes.

All original forms and scans are kept in the health facility for at least three (3) years. The parent or guardian should have a copy of the registry form and official result, ideally attached or recorded in the infants “baby book.”

V. CATEGORIES OF CENTERS AND REQUIREMENTS

The UNHS program is best organized if you have a multi-disciplinary approach at the outset. A medical home concept for newborns is the most ideal set-up, which emphasizes on the role of the primary care physician with the full complement of a pediatrician, otorhinolaryngologists and speech therapists. More so, coordination of specialty medical care, provision for referrals for various services, assurance of timely follow-up and medical interface for medical interventions are also crucial to ensure program efficiency among NHSPs.

A. CATEGORIES OF SCREENING CENTERS

1. *Category A (Newborn Hearing Screening Center)*

This center has the capacity to do hearing loss screening and could also provide for the preventive aspect of hearing impairment.

2. *Category B (Newborn Hearing Diagnostic Center)*

This center can do both hearing loss screening and initial audiologic diagnostic evaluation such as an Audiometric Brainstem Response (ABR)/ Audiometric Steady State Response (ASSR). This facility will act as coordinator for the surrounding Category A Newborn Hearing Screening Centers. Each province should have at least one Category B center.

3. *Category C (Newborn Hearing Diagnostic and Intervention Center)*

This center has the capacity to do hearing screening, repeat OAE and/or ABR and hearing aid fitting; at least one center should be present per region. This is the lowest category for a Regional Database Center.

4. Category D (Newborn Hearing Diagnostic, Intervention, Surgical and Rehabilitation Center)

This center has the capacity to do newborn hearing screening, repeat ABR/ASSR, hearing aid fitting, ear surgery, cochlear implantation and speech rehabilitation

Newborn Hearing Screening Reference Center (NHSRC)

A central facility of the National Institutes of Health that defines testing and follow-up protocols, maintains an external laboratory proficiency testing program, oversees the national testing database and case registries, assists government and non-government agencies in the training activities in all aspects of the program, and oversees content of educational materials.

B. REQUIREMENTS FOR PERSONNEL

All personnel involved in the NHSP should undergo a certifying course. All personnel in newborn hearing screening centers should at least be 19 years old high school graduate, proficient in English, with good communication skills. Managers such as physicians (ENT, Pediatricians, Family Physicians, General Practitioners, etc) and audiologists shall submit appropriate credentials. Physicians and other members of the health care team should be currently licensed. Applications for NHSC personnel training shall be submitted to the NHSRC. The application form (Appendix U) shall be made available for download through the NIH, NHSRC and DOH websites. Certifying training programs for all personnel, including managers (doctors and audiologists), shall be conducted by the NHSRC and shall be coordinated with the DOH. The training programs will include didactics, skills building, return demonstration and written evaluation and shall be consistent with DOH standards. Objective demonstration of competence above a minimum passing level and compliance with DOH regulations is required for continued certification.

C. REQUIREMENTS FOR CENTERS

Onsite inspection of facility and equipment will be done by the DOH in coordination with the NHSRC. ***The DOH has the sole authority to give the licensing for operation of Newborn Hearing Screening Centers.***

Managers of Newborn Hearing Screening Centers should have passed the Category specific certifying courses and requirements prior to submission of application for licensing. Application forms (Appendix V) which are available for download from the NHSRC and DOH websites for the certification and checklist for basic requirements for category specific Newborn Hearing Screening Centers shall be submitted to the NHSRC to verify manager and personnel credentials then forwarded to the Department of Health for facility licensing. Only the DOH can issue a facility code for free standing or independent newborn hearing facilities. Those NHSCs operating within DOH recognized health facilities which includes public-private partnership agreements / out-sourced services with memorandum of agreements shall be considered part of the entire facility. Public-private partnership agreements or out-sourced services must have an area or archiving space within the health facility or hospital. No records such as the official result or yellow forms may be removed within the premises of the health facility as they are technically official records of the patients and may be inspected by the DOH.

Onsite inspection of facility and equipment will be done by the DOH in coordination with the NHSRC. ***The DOH has the sole authority to give the certification for operation of Newborn Hearing Screening Centers.***

1. Category A: Newborn Hearing Screening Center

- Duration: Certification should be renewed every three (3) years
- Facility: Testing may be done at bedside or any quiet area as long as acquisition of OAE or AABR is possible. There must be a designated accessible archiving area for test results and yellow registry forms.
- For free standing centers, the area of the office should be at least 3 x 3 sq. meters with ambient sound not greater than (\leq) 40 dB.
- Equipment: Otoacoustic emission test machine (either a transient-evoked or distortion product type) and/or an Automated Audiometric Brainstem Response (AABR) Test Machine
- Connectivity: Access to a computer with internet (not necessarily within the center premises), spreadsheet program (MS Excel Open Office), and data capturing device capable of electronic transmission (such as scanner, computer camera, cellphone smartphone, tablet with camera)

Personnel: Licensed physician or clinical audiologist (graduate of Masters in Clinical Audiology) to perform screening and manage the center, passed the Category A Newborn Hearing Screening certifying course and is able to send electronic monthly reports to the NHSRC.

Optional: Adult personnel (≥ 19 years old), at least high school graduate, proficient in English, with good communication skills who passed the Category A Newborn Hearing Screening certifying course given by the NHSRC.

2. Category B: Newborn Hearing Diagnostic Center

Licensing: Certification should be renewed every three (3) years

Facility: Dedicated sound treated room at least 3 x 4 sq. meters, with bed, that could accommodate audiologic equipment and archiving of results and yellow registry forms.

Connectivity: Dedicated computer with internet, spreadsheet program (MS Excel Open Office), and data capturing device capable of electronic transmission (such as scanner, computer camera, cellphone smartphone, tablet with camera)

Equipment: 1. Otoacoustic Emission Test Machine (Distortion Product type or DPOAE) and/or Automated Auditory Brainstem Response (AABR)
2. Auditory Brainstem Response (ABR) Machine and/or Auditory Steady State Response (ASSR)
3. Immittance Machine (Tympanometer)
4. Clinical Audiometer with play audiometry capabilities

Personnel: 1. Manager: Clinical audiologist (Masters in Clinical Audiology graduate) who has passed the Category A Newborn Hearing Screening Certifying Course and submitted his/her diploma. The audiologist reads the confirmatory tests, acts as manager and is able to send electronically monthly reports to the NHSRC
2. Licensed physician (general practitioner, family physician, pediatrician, etc) who has attended an Orientation Course on RA 9709 who will act as clinical management and treatment advisor to the manager.

Optional: Adult personnel (>= 19 years old), at least high school graduate, proficient in English, with good communication skills who passed the Category A Newborn Hearing Screening Certifying Course given by the NHSRC.

3. Category C: Newborn Hearing Diagnostic and Intervention Center

Licensing: Licensing should be renewed every three (3) years.

Facility: Sound treated, dedicated room, at least 3 x 4 sq. meters with one (1) bed, that could accommodate audiologic equipment and archiving or results and yellow registry forms.

Connectivity: Dedicated computer with internet, spreadsheet program (MS Excel Open Office), and data capturing device capable of electronic transmission (such as scanner, computer camera, cellphone smartphone, tablet with camera)

Equipment: 1. Otoacoustic Emission Test Machine (Distortion Product type or DPOAE) and or AABR
2. Audiometric Brainstem Response (ABR) and /or ASSR;
3. Immittance Machine (Tympanometer)
4. Clinical Audiometer with play audiometry capabilities
5. Hearing aid fitting equipment

Personnel: 1. Manager: Clinical audiologist (Masters in Clinical Audiology graduate) who has passed the Category A Newborn Hearing Screening Certifying Course and submitted his/her diploma. The audiologist reads the confirmatory tests, acts as manager and is able to send electronically monthly reports to the NHSRC
2. Advisor: Otorhinolaryngologist (Diplomate of the Philippine Society of Otorhinolaryngology-Head & Neck Surgery) who has attended an Orientation Course on RA 9709 who will act as clinical management and treatment advisor.

Optional: Adult personnel (>= 19 years old), at least high school graduate, proficient in English, with good communication skills who passed the NHS training program given by the NHSRC.

4. Category D (Newborn Hearing Diagnostic Intervention Surgical and Rehabilitation Center or Team)

Licensing: Licensing should be renewed every three (3) years.

- Facility: Sound treated, dedicated room, at least 3 x 4 sq. meters with a bed, that could accommodate audiologic equipment and archiving for results and yellow copy of the registry forms.
- Connectivity: Dedicated computer with internet, spreadsheet program (MS Excel Open Office), scanner, camera, or data capturing device capable of electronic transmission (such as cellphone, smartphone, tablet with camera)
- Equipment: 1. Otoacoustic Emission Test Machine (Distortion Product type or DPOAE) and/or AABR;
2. Audiometric Brainstem Response (ABR)and/or ASSR;
3. Immittance Machine (Tympanometer)
4. Clinical Audiometer with play audiometry capabilities
5. Hearing aid fitting equipment
- Personnel: 1. Manager: Clinical audiologist (Masters in Clinical Audiology graduate) who has passed the Category A Newborn Hearing Screening Certifying Course and submitted his/her diploma. The clinical audiologist reads the confirmatory tests. There may be more than one clinical audiologist in this center. However, only one may be designated as manager who is responsible for diagnostic accuracy, reporting and archiving of data in the center.
2. Coordinator: Otorhinolaryngologist (Diplomate of the Philippine Society of Otorhinolaryngology-Head & Neck Surgery), who has attended an Orientation Course on RA 9709 who will act as coordinator for clinical management and treatment of the team. The coordinator must be a practitioner within the center's geographic area of service. The coordinator tracks the referral system and is in-contact with all members of the team managing the infant. There can only be one designated coordinator per team.
3. Surgeon: Otorhinolaryngologist (Diplomate of the Philippine Society of Otorhinolaryngology-Head & Neck Surgery), certified in implantable hearing devices surgery, who has attended an Orientation Course on RA 9709. The implant surgeon may or may not be the coordinator for the Category D Team. Centers may have several implant surgeons.
3. Speech therapist/speech pathologist, occupational therapist who has attended an Orientation Course on RA 9709 who will act as clinical management and treatment advisor of the team. They must be practitioners

within the center's geographic area of service. Centers may have several speech and occupational therapists in the team

4. Developmental pediatrician who has attended an Orientation Course on RA 9709 who will act as clinical management and treatment advisor of the team. They must be practitioners within the center's geographic area of service. Centers may have several developmental pediatricians in the team.

Optional: Adult personnel (>= 19 years old), at least high school graduate, proficient in English, with good communication skills who passed the Category A Newborn Hearing Screening Certifying Course given by the NHSRC.

Pediatric Neurologist, Pediatric Endocrinologist / geneticist, Clinical Psychologist, other personnel who have attended an Orientation Course on RA 9709

Note: Category D Center or Team should have an office same as Category C with a manager, connectivity and archiving facilities. All members of the team should be readily available

Newborn Hearing Screening Reference Center

A central facility located at the National Institutes of Health, University of the Philippines Manila that defines testing and follow-up protocols, maintains an external laboratory proficiency testing program, oversees the national testing database and case registries, assists government and non-government agencies in the training activities in all aspects of the program, and oversees content of instructional and educational materials. The director is a board certified Otolaryngologist of the Philippine Board of Otolaryngology Head and Neck Surgery or a clinical audiologist, resident of the Philippines who has completed a Masters in Clinical Audiology course.

VI. ROLES AND RESPONSIBILITIES OF UNHS IMPLEMENTERS

A. National Center for Disease Prevention and Control, Department of Health

The DOH shall be the lead agency in implementing the provisions of this Act. For this purpose, the DOH shall perform the following functions:

1. Develop a comprehensive program for prevention and management of hearing loss of children.
2. Appropriate, leverage, and mobilize resources of the various offices within the DOH, NHSRC-NIH, PhilHealth, and other health related facilities, and other external resources to fully implement the program.
3. Enjoin local government, stakeholders, concerned health personnel and workers at all levels to fully implement the program.
4. Expand the Advisory Committee on Newborn Screening to include representatives for newborn hearing screening.
5. Coordinate with other national government agencies, local government units (LGU), health professional organizations and societies, funding agencies, development partners, socio-civic organizations private sectors and others in the implementation of the program.
6. Include newborn hearing screening in its health communication plan, advocacy and social mobilization campaigns.
7. Coordinate with the NHSRC-NIH for the following:
 - a. Certification of NHSC personnel
 - b. Determining the prescribed screening methods, hearing loss confirmatory tests, interventions and alternative methods if any
 - c. Preparation of defined testing protocols and quality assurance programs.
 - d. Maintenance and improvement of the NHS registry.
 - e. Development of alternative hearing screening methods, instruments, and procedures.
 - f. Definition of candidacy and the promulgation of selection criteria regarding appropriate treatment and/or rehabilitative interventions for the deaf or hearing-impaired child.
 - g. Production and distribution of newborn hearing screening registry cards.
 - h. Preparation and distribution of advocacy campaign activities and dissemination of public information materials.
 - i. Preparation of annual budget from the general appropriations act (GAA) regarding setting-up of infrastructure, procurement of equipment and manpower concerning Newborn Hearing Screening and Intervention in DOH retained health facilities nationwide.

- j. Determination of fees to be levied for registry cards, certification of personnel and NHS centers, and other technical advisory services on newborn hearing such as but not limited to newborn hearing screening or diagnostic devices and alternative methods evaluation.
- 8. Formulate policies for the institutionalization of the program at all levels of implementation. Integrate the NHSP into the current health care delivery system. It shall become part and parcel of a routine procedure for newborn in hospitals, public and private health institutions.
- 9. Ensure that a network for prompt recall of those with “Refer” results is established in collaboration with the LGUs, government agencies, and other non-government organizations.
- 10. Establish a network of hospitals, health facilities and diagnostic hearing centers for the referral and management of those newborns who had “Refer” results for confirmatory testing and intervention if needed.
- 11. Coordinate with the following groups for their possible role in the implementation of the UNHSIP:
 - a. Patients’ support groups and service provider delivery groups involved in attending to the needs and concern of individuals who are deaf and hard-of-hearing and their families.
 - b. Qualified professional personnel who are proficient in deaf or hard-of-hearing children’s language and who possess the specialized knowledge, skills and attributes needed to serve deaf and hard-of-hearing infants, toddlers, children and their families.
 - c. Other health and education professionals and organizations. Monitor the extent to which hearing screening and evaluation are conducted in health institutions, and assist in the development of UNHSIPs for hospitals, health institutions and diagnostic hearing centers. The DOH shall require these healthcare institutions to periodically submit data on newborns screened in their facility and include compliance to this function as a criterion for renewal of certification.

B. Newborn Hearing Screening Reference Center, National Institutes of Health

The Newborn Hearing Screening Reference Center –National Institutes of Health (NSHRC-NIH) as technical arm of the Department of Health shall assist on the following;

1. Defines and recommends newborn hearing screening testing and follow-up protocols which includes hearing screening methods, devices used, location, manner and timing of newborn hearing testing.
2. Conducts personnel certifying courses together with the DOH.
3. Conducts testing and certification of newborn hearing screening devices and methods with the DOH.
4. Distributes newborn hearing screening registry cards and levies fees as approved by the DOH.
5. Distributes advisory and advocacy materials in coordination with DOH.
6. Maintains and oversees the national hearing screening database and case registries.
7. Assists government and non-government agencies in all aspects of the program including implementation, training, awareness campaigns including overseeing content of educational and other instructional materials.

C. Advisory Committee on Newborn Hearing Screening

To ensure sustainable inter-agency collaboration, the Advisory Committee on NHS shall be created and made an integral part of the Office of the Secretary.

The composition of the Advisory Committee on NBS created under Section 11 of Republic Act No, 9288, “Newborn Screening Act of 2004” shall be expanded to include the representatives from the PSO-HNS and the Philippine Society of Audiology. The committee shall be composed of:

1. Secretary of Health, who shall act as Chairperson;
2. Executive Director of the National Institutes of Health, who shall act as Vice Chairperson;
3. Undersecretary of the DILG;
4. Executive Director of the Council for the Welfare of Children;
5. Director of the NSRC;
6. Executive Director of the NHSRC;

7. Representative of the PSO-HNS;
 8. Representative of the Philippine Society of Audiology;
- and three (3) representatives appointed by the Secretary of Health who shall either be a pediatrician, obstetrician-gynecologist, endocrinologist, family physician, nurse or midwife, from either the public or private sector. The three (3) representatives shall be appointed for a term of three (3) years, subject to their being reappointed for additional three (3) year periods for each extension.

Functions of the Advisory Committee on Newborn Hearing Screening:

1. Review annually and recommend risk factors to be included in the NHS.
2. Review and recommend the standard NHS hearing screening fees to be charged by NHSC for each newborn.
3. Review the report and recommendations of the TWG-UNHSP and NHSRC on the quality assurance of the NHSCs.
4. Recommend corrective measures and strategic directions as deemed necessary.

The ACNHS shall meet at least twice a year. The National Institutes of Health shall serve as the Secretariat of the Committee.

D. Technical Working Group (TWG) on UNHSIP

The TWG shall be composed of the following but not limited to:

1. Representatives from DOH offices namely: NCDPC, National Epidemiology Center (NEC), National Center for Health Facility Development (NCHFD), Bureau of Health Facility and Services (BHFS), National Health Promotion (NCHP)
2. Representatives from the Center for Health and Development
3. Representatives from Philippine National Ear Institute (PNEI-NIH),
4. Representatives from the NGO sector
5. Representatives from the PSO-HNS
6. Representatives from the Disability Affairs Office
7. Representatives from the Newborn Hearing Screening Reference Center (NHSRC-NIH)

8. Representatives from the Philippine Hospital Association
9. Representatives from the Academe

It shall have the following responsibilities and functions:

1. Develop policies standards and guidelines on newborn hearing screening for recommendations and approval and management.
2. Develop educational materials for both training and public dissemination.
3. Review and recommend the newborn hearing screening fees to be charged by the newborn hearing screening center.
4. Develop/review strategies and tools that will ensure effective and efficient implementation of the program at various levels.
5. Formulate national program plans, proposal and collaborative studies on
6. newborn hearing screening.
7. Review the report of the Newborn Hearing Screening Reference Center on the performance of the newborn hearing screening centers and recommend corrective measures as deemed necessary.

E. Health Facilities and Services Regulatory Bureau (HFSRB)

The BFSRB, collaboration with NIH shall be responsible for regulating health facilities performing newborn hearing screening procedures through:

1. Accreditation procedures and monitoring for compliance and quality assurance.
2. Development of needed rules and regulations pertaining to the regulation of the same.
3. Monitoring and evaluation of newborn hearing screening centers.

F. Epidemiology Bureau (EB)

The NEC in collaboration with the regional/provincial epidemiology unit shall be responsible for developing a surveillance system for heritable conditions. It shall establish registry of cases linked with NIH as the central registry center, and the rural health unit as the base registry units.

G. Health Facility Development Bureau (HFDB)

The HFDB shall participate in providing technical assistance and leadership for the continuous effective implementation of the Newborn Hearing Screening in the Hospital in coordination with the Regional Office's. It shall encourage hospitals to participate in the

monitoring and participation in the research and development efforts that will be pursued and initiated by concerned stakeholders and the NIH.

H. Health Promotion and Communication Service (HPCS)

The HPCS shall act as the lead office in the promotion of newborn hearing screening and shall develop advocacy materials for dissemination to all partner agencies (LGUs, Academe, NGOs) and stakeholders. All IEC materials and collaterals shall be screened and reviewed by HPCS.

I. Bureau of Health Devices and Technology

BHDT shall assist the program in the monitors, evaluation and ensures compliance of manufacturers, distributors, advertisers and retailers of health and health-related devices and technology to health rules and regulations and standards of quality.

J. Regional Office's (RO's)

The RO'S shall be responsible for the following:

1. Translate and implement newborn hearing screening national policies and framework at the local and regional level.
2. Provide technical and logistics assistance to LGUs, NGOs, Academic Institution, and other stakeholders.
3. Advocate for the implementation of newborn hearing screening at the regional level.
4. Reproduce newborn screening advocacy materials for general distribution.
5. Conduct training orientation and training on newborn hearing screening.
6. Host locally organized Category A Newborn Hearing Screening Certifying Courses with the help of certified local newborn hearing personnel.
7. Develop innovative approaches and models of implementation on newborn screening and local partners.
8. Establish a government and private sector collaborative partnership to plan and manage the newborn hearing screening implementation in the region.
9. Monitor and evaluate the implementation in the region.

K. DOH Retained Hospitals, Other government and private hospitals and lying-ins.

All DOH Retained Hospitals other government and private hospitals clinics and other health facilities shall be responsible for the following:

1. Create an NHS team to ensure implementation of NHS and coordinate with DOH.
2. Ensure that adequate and sustained newborn hearing screening services such as information, education, communication, screening recall and management of identified cases are being provided in the hospital.
3. Establish an appropriate financial system that will ensure effective and efficient collection of fees and payment of NHS registry fees through the purchase of the NHS registry card.
4. Conduct orientation and/or training of hospital staff on newborn hearing screening and intervention.
5. Monitor and evaluate the implementation of newborn screening within the institution.
6. Define financial packages to make newborn hearing screening, confirmatory testing and hearing loss intervention accessible particularly among the economically deprived population.
7. Establish a functional referral system with local as well national agencies

L. Department of Interior and Local Government (DILG)

Shall advocate and encourage the cooperation of LGUs to take an active role in the implementation of RA 9709. Assist the DOH in the monitoring and evaluation of the program.

The LGUs through the Chief of Hospitals and Municipal Health Officers shall be responsible for the following:

1. Develop the capabilities of health workers in the implementation of RA 9709. Government health physicians and other designated health workers should be trained and certified to conduct hearing screening tests on all newborns in their locality.

2. Appropriate budget for the training and certification of their public health workers on how to do newborn hearing screening.
3. Issue local ordinances and resolutions that integrate Newborn Hearing Screening and Intervention in the local health delivery system and the appropriation of budget such as, but not limited to, the following:
 - a. hearing screening, confirmatory equipment; and
 - b. Referral of a newborn detected with hearing loss to a center for further evaluation and intervention if they are not available in the locality.

Operation of RA 9709;

 - c. Training and certification of personnel on how to conduct hearing screening;
 - d. Establishment of appropriate NHSC by category in the locality;
4. Ensure that adequate and sustained local UNHSIP through continued information dissemination, education, screening, confirmation of hearing loss, recall, and follow-up.
5. Establish a functional case management for the recall and referral system with a strategically accessible NHS health facility referral center.
6. Establish coordination and networking among concerned agencies in the implementation of the program.
7. Monitor and evaluate the implementation of the program in their localities.
8. Explore/encourage creative health financing packages to make newborn hearing screening accessible particularly among the economically deprived populace.
9. Perform other roles and responsibilities as deemed necessary.

M. Council for the Welfare of Children

1. Integrate NHS in the establishment of the system for early detection, prevention, referral and intervention of congenital hearing loss and disabilities in early childhood.
2. Promote NHS as an integral part of the Early Childhood and Care Development (ECCD) programs implemented at the national, regional and local levels.

3. Provide avenues in developing innovative advocacy and communication approaches and social mobilization in partnership with civil societies, non-government organizations and other groups.
4. Include NHS-related indicators in the monitoring and evaluation system of child advocacy programs.

N. Academe, Health Professional Societies, National Organization of Health Professionals shall:

1. Ensure that all its members are aware of the significance of newborn hearing screening and early intervention to their clients, families and the society at large.
2. Define mechanisms that will ensure and monitor that its members are doing their moral and social obligations to inform parents about the significance of Newborn Hearing Screening and Early Intervention.
3. Recommend the inclusion of NHS as part of the curricula of all allied health professionals.

VII. RESEARCH AND DEVELOPMENT

Robust information from actual operations is needed to provide evidence of the achievement of the goals set out by the law. Such information can be obtained from the data generated from screening, further testing and early intervention activities, captured and aggregated as near real time as possible. Data must flow through all levels of the UNHS program in an open and transparent manner in order to inform decisions regarding policies. Security of patient information must always be protected and respected.

The data gathered will be used to build a national registry that will track interventions and outcomes of newborns with hearing impairment.

A. CORE DATASET

Aside from the data elements, mostly patient identifiers and hearing screening results in the NHS Registry Card the following will also be reported by the NHS Centers:

1. Patient Identifiers, Hearing Screening Results and Risk Factors – NHS Registry Card

2. Interventions

Date of initial referral to intervention facility
 Type of intervention: facility based / home based
 Name of provider:
 Date of first enrollment (onset of intervention)
 Functional communication: oral /sign/none
 Hearing aid: right ear / left ear
 Other devices: right ear / left ear

3. Referrals from the community, other facilities

Referral for diagnostic ABR/ASSR
 Referral for behavioral audiometry / VRA
 Referral for hearing aid fitting
 Referral for surgery (includes cochlear implant, BAHA, microtia surgery)
 Referral for speech therapy, hearing rehabilitation
 Referral for occupational therapy (includes other types of communication sign language, etc.)
 Duration to see: delay in referrals
 Reasons for delays in referral

B. PERFORMANCE INDICATORS

Indicator data will be aggregated at the regional and national level for trending, provider profiling and benchmarking with local and international standards.

1. Percentage (%) of facility births screened prior to discharge or within 3 months (calculated from total number of newborns screened divided by total newborns in the facility.)
2. Referral rate (calculated from total number of newborns referred to Newborn Hearing Screening Reference Center/ audiology center divided by total number of newborns screened by NHSC.)
3. Average time from NHSC referral to audiological assessment.
4. Yield – calculated as number of newborns with audilogically diagnosed hearing impairment divided by total newborns screened by NHSC.

5. Percentage of DOH-licensed and PhilHealth accredited facilities that are providing newborn hearing screening services with or without utilization of PHIC newborn package

6. Other indicators at Newborn Hearing Screening Center

- % of newborns screened who fail initial screening
- % of newborns screened who fail second screening
- % of screened newborns who fail re-screening referred for further audiological evaluation (confirmatory)
- % of screened newborns with permanent childhood hearing impairment, moderate-severe HI
- % of screened newborns with HI referred for habilitation (hearing aid or cochlear implantation)
- % of screened newborns with HI referred for speech therapy
- % of families of newborns refusing screening (identify reasons)
- % of newborns who failed initial screen not coming back for re-screen
- % of newborns who fail re-screen not referred or submitting for confirmatory tests or further audiological tests

The data set can be used by every local hearing program or accredited newborn hearing center for management and audit. It is envisioned that an online system will be developed which allows providers and public health officials to benchmark their performance, monitor improvement, compare their services with national standards. Specific data can be exported enabling the creation of a focused report.

Furthermore, the core data set will be used for the following:

- Establishment of a national hearing registry
- Program evaluation within 1 year
- Development of efficient data management and monitoring from screening, diagnosis to intervention
- Cost-effectiveness study of existing UNHSP
- Identification of causes and risk factors for hearing loss (e.g. proportion of rubella among PCHI patients --- highlight improvement in vaccination coverage)
- Formulation of outcomes research (speech & language development, QOL post-intervention)

- Development of community –based screening methods
- Identification of motivating factors for submitting for hearing screening
- Determination of effectiveness of active vs passive surveillance among local health workers in identifying babies with HI
- Development of reliable and valid alternative hearing screeners in the community to identify suspected infants for facilitation of referral to NHSCs
- Identification of methods to enhancing availability and accessibility of NHSCs
- Development of efficient hospital-based screening protocols
- Identification of motivating factors for submitting for hearing screening
- Development of process evaluation (conduct of screening-referral for audiologic testing-referral for habilitation-referral for speech therapy-documentation-reporting) to identify factors in enhancement of the implementation of the program and attainment of program objectives

C. MONITORING AND EVALUATION

Monitoring of newborn hearing screening shall be incorporated in the routine monitoring activities of the DOH and NHSRC. The DOH may conduct inspections on NHS centers and may sanction centers and personnel not following the MOO. The NHSRC shall monitor the reporting and referral systems of NHS centers and shall report to the DOH delinquent NHS centers.

All NHSCs must be annually reviewed in terms of compliance with the following standards:

1. Contract -Based Standards - On terms of reference of contract, if NHS provider is a contracted agency of a bigger facility or hospital
2. Technical Standards - If the NHS provider operates and maintains its facility and equipment in terms of technical specifications and standards established by audiological sources and the device manufacturers
3. Customer Service Performance - Demonstrating the NHS provider's efforts and acumen at providing customer service. The components of this section will include:

- a. Inquiry and Complaint Tracking Database - listing incidents by source, types, and outcomes.
 - b. Customer Survey – based on customer service surveys. Service will be rated based on a statistical evaluation of customer responses.
4. NHS Performance Standards - Based on operations standards set forth by this manual, including any notices of exceptions or instances of non-compliance and provider's performance in curing those deficiencies. Also, consideration will be given to a NHS provider's active participation in the UNHS program, projects, committees, task forces, etc., and multi-agency training exercises. Also includes:
- a. Qualifications of clinical personnel (including certifications and continuing education)
 - b. Maintaining all required clinical equipment in good working order
 - c. Adherence to clinical protocols
 - d. Clinical Performance – Based on clinical outcomes of screening the NHS operations. This includes Quality Improvement Processes such as referral rates, yields and turnaround times.

VIII. FUNDING AND SUSTAINABILITY

All offices concerned shall allocate resources in support of the newborn hearing screening system. External agencies are encouraged to provide funds for the implementation of newborn hearing screening and early intervention.

Funds for the program shall be derived from the funds for Child Health and Development. Supplemental funds and other resources shall be sourced out from extension services and other key stakeholders. LGUs shall be encouraged to provide funds for the implementation of newborn hearing screening program.

Funds from the sale of newborn hearing screening registry cards, fees from certifying courses, fees from device and alternative methods evaluation and other technical advisory services related to newborn hearing screening and intervention shall be used to maintain the operations of the NHSRC which is primarily but is not limited to the maintenance of the newborn hearing screening registry database.

A. Components Needing Funding

There are approximately 2 million newborns per year, 80% of whom are born at home and 50% are indigent. To implement the program, the following are the components that need funding:

Newborn Hearing Screening Centers in regions where there are no private licensed providers:

1. Screening equipment such as OAE and AABR
2. Confirmatory or definitive tests such as ABR, ASSR and behavioral tests
3. Hearing aid fitting equipment
4. Staff (manager, audiometricians, audiologists) for the centers

Department of Health (CHD) and NIH-NHSRC:

1. Training workshops (honorarium for facilitators, manuals, exam and certificates)
2. NHS Center licensing (transportation cost and honorarium of inspector)
3. Registry forms
4. Courier / electronic transmission fees for forms
5. Registry / data management facility at the NIH
6. Salaries of NIH-NHSRC staff
7. Project development
8. Educational materials development
9. Information dissemination and advocacy activities
10. Database development
11. Standards development (evaluation of new methods and technologies)

B. Sources of Funding

The following can be the sources of funding:

1. General Appropriations Act - DOH/NIH Philippines
2. Philippine Health Insurance Corporation (PhilHealth)
3. PCSO and other funding institutions
4. Fees derived from certification and training
5. Income from sale of NIH newborn registry cards
6. Donations from the private sector

C. Sustainability of the Program

It is envisioned that all NHSC will be financially sustainable not just from provision of hearing tests but also from a broader array for hearing services for the hearing impaired covering a wider population base. Centers must strive to provide services that are of real value while improving internal efficiencies and achieving economies of scale.

IX. ADVOCACY AND INFORMATION DISSEMINATION FOR UNHS

The objectives for advocacy and information dissemination are to provide awareness of the Universal Newborn Hearing Screening Program and to encourage those who are already practicing to continue with the implementation of UNHS.

The target groups are parents, potential parents (those applying for a marriage license) or guardians as well as the different disciplines, organizations who provide care to women and children. Dissemination can be carried out through seminars/workshops, broadcast media, internet, social networking or small print media such as posters or brochures advocated by the NIH and DOH.

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16. Department of Health, Republic of the Philippines Administrative Order No. 2010-0020.
17. Republic of the Philippines Philhealth Circular No. 011-2011.

APPENDIX A

Republic Act 9709

S. NO. 2390
H. No. 2677

Republic of the Philippines
Congress of the Philippines
Metro Manila
Fourteenth Congress
Second Regular Session

Begun and held in Metro Manila, on Monday, the twenty-eighth day of July, two thousand eight.

[REPUBLIC ACT NO. 9709]

AN ACT ESTABLISHING A UNIVERSAL NEWBORN HEARING SCREENING PROGRAM FOR THE PREVENTION, EARLY DIAGNOSIS AND INTERVENTION OF HEARING LOSS

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled:

SECTION 1. *Short Title.* – This Act shall be known as the "Universal Newborn Hearing Screening and Intervention Act of 2009".

SEC. 19. *Effectivity Clause.* – This Act shall take effect fifteen (15) days after its publication in at least two (2) newspapers of general circulation.

Approved,

PROSPERO C. NOGRALES
Speaker of the House of Representatives

JUAN P. ENRIQUE
President of the Senate

This Act which is a consolidation of Senate Bill No. 2390 and House Bill No. 2677 was finally passed by the Senate and the House of Representatives on June 3, 2009.

MARILYN B. BARUA-YAG
Secretary General House of Representatives

EMMA LIRIO-REYES
Secretary of the Senate

Approved: AUG 12 2009

Gloria M. Arroyo
GLORIA MACAPAGAL-ARROYO
President of the Philippines

0



http://www.senate.gov.ph/republic_acts/ra%209709.pdf

APPENDIX B

Administrative Order No. 2010-0020



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

June 28, 2010

ADMINISTRATIVE ORDERNo. 2010 – 0020

SUBJECT: RULES AND REGULATIONS IMPLEMENTING REPUBLIC ACT (R.A.) NO. 9709 OTHERWISE KNOWN AS THE “UNIVERSAL NEWBORN HEARING SCREENING ACT OF 2009”

The following rules and regulations are hereby promulgated to implement **Republic Act (R.A.) No. 9709**, otherwise known as the **Universal Newborn Hearing Screening and Intervention Act of 2009**, an act establishing a **Universal Newborn Hearing Screening (UNHSP) Program** for the prevention, early diagnosis, and intervention of hearing loss.

SECTION 29. *Effectivity Clause* – This Implementing Rules and Regulation shall take effect immediately after its publication in a newspaper of general circulation.


ESPERANZA I. CABRAL, MD
Secretary of Health

APPENDIX C

Philhealth Circular No. 011-2011



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
 Citystate Centre, 709 Shaw Boulevard, Pasig City
 Healthline 637-9999 www.philhealth.gov.ph



PHILHEALTH CIRCULAR

No. 011-2011

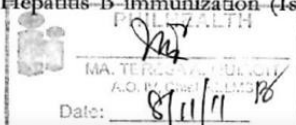
Key -

To : All PhilHealth Stakeholders and All Concerned

Subject : New PhilHealth Case Rates for Selected Medical Cases and Surgical Procedures and the No Balance Billing Policy

C. Newborn Care Package (NCP)

1. The package shall be increased to One Thousand Seven Hundred and Fifty Pesos (Php 1,750) which shall include the following services, immediate drying of the newborn, early skin-to-skin contact, cord clamping, non-separation of mother/baby for early breastfeeding initiation, eye prophylaxis, Vitamin K administration, weighing of the newborn, BCG vaccination, Hepatitis-B immunization (1st dose), Newborn



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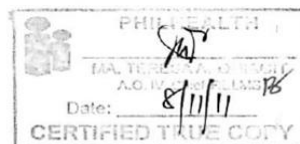
- Screening Test (NBS), Newborn Hearing Screening Test, and Professional fee (that includes breastfeeding advice and physical examination of the baby, among others).
2. In instances when the enumerated services for NCP above were not provided completely or patient-members were asked to purchase/access services outside the facility and an Official receipt is attached to the claim, the member shall be reimbursed all eligible expenses detailed in the attached OR/s with the said payment to the member deducted from the case payment that would be paid to the health facility.
 3. In instances where, upon post-audit, services were not rendered or were not complete as shown above, then these shall be charged to future claims of the health facility with corresponding sanctions or penalties the Corporation may charge
 4. All NCP claims are covered by the NBB Policy as described in Section III.

XI. Effectivity

This Circular shall take effect for all claims with admission date of September 1, 2011. Further, this Circular shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

DR. REY B. AQUINO
 President and CEO

Date signed: *8/11/11*



PhilHealth

Your Partner in Health



OP-S11-43026

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APPENDIX D

Refusal Form English

NEWBORN HEARING SCREENING REFUSAL FORM (English)

Date: _____

Facility: _____

Republic Act 9709 also known as the “*Universal Newborn Hearing Screening and Intervention Act of 2009*” is a comprehensive national program to ensure that every newborn in the Philippines shall be given access to Otoacoustic Emissions or Automated Auditory Brainstem Response screening examination prior to hospital discharge or at the earliest feasible time. An infant born with hearing impairment does not show obvious symptoms. Hearing is important so that a child will be able to speak. A child who grows up deaf will have difficulty in speaking and learning.

The screener in this facility informed the undersigned of newborn hearing screening, its procedure, its benefits, its availability in this facility and the consequences of undiagnosed deafness in infants.

As parent/guardian of _____, I refuse to have newborn hearing screening done for the following reason/s:

I declare with full knowledge and competence that this institution and the health workers therein shall be free from all liabilities under the law because this refusal for newborn hearing screening is of my decision.

I understand that a copy of this refusal form shall be part of the permanent medical records of my child/ward and will be part of a national registry/database of the Newborn Hearing Screening Reference Center.

Witnesses:

Signature over Printed Name of
Parent/Guardian

Signature over Printed Name of
Screener

APPENDIX E

Refusal Form Filipino

NEWBORN HEARING SCREENING PAGTANGGI SA SERBISYO (Filipino)

Petsa: _____

Pasilidad: _____

Ang Republic Act 9709, kilala bilang “*Universal Newborn Hearing Screening and Intervention Act of 2009*” ay isang komprehensibong programang pambansa na sinisiguro na bawat sanggol na ipinanganak sa Pilipinas ay mabibigyan ng pagkakataon na masuri ang pandinig gamit ang Otoacoustic Emissions o Automated Auditory Brainstem Response bago umuwi sa bahay o sa lalong madaling panahon. Ang sanggol na ipinanganak na may kapansanan sa pandinig ay walang sintomas kaya’t hindi agad nasusuri. Ang pandinig ay mahalaga para makapagsalita ang bata. Ang batang lumaking bingi ay mahihirapan sa pakikipagusap at pag-aaral.

Ang screener sa pasilidad na ito ay nagbigay ng sapat na impormasyon tungkol sa pagsusuri sa pandinig ng sanggol, kung papaano ito ginagawa, mga benepisyo nito, na ang serbisyong ito ay binibigay ng pasilidad na ito at ang maaaring mangyari kapag hindi malaman agad ang pagkabingi sa sanggol.

Ako na magulang o tagapagalaga ni _____, ay hindi pumapayag na gawin ang newborn hearing screening dahil sa:

Pinaninindigan ko ang aking desisyon at nalalaman ko na ang institusyon na ito at ang mga manggagawa dito ay walang pananagutan ayon sa batas dahil ang pagtanggi ko sa newborn hearing screening para sa aking anak o alaga. Ito ay tanging decision ko lamang.

Nalalaman ko na ang kopya ng pagtanggi na ito ay malalagay sa permanenteng medical record ng aking anak o alaga at ito ay magiging bahagi din ng registry/database ng Newborn Hearing Screening Reference Center.

Mga Saksi:

Lagda sa ibabaw ng Pangalan ng
Magulang o Tagapagalaga

Lagda sa ibabaw ng Pangalan ng
Screener

APPENDIX F

UNHS High Risk Questionnaires For Community-Based Facilities*

Level 1 Questionnaire



Universal Newborn hearing Screening
Community-Based Program

Questionnaire for Screening Congenital Hearing Impairment
(Primary Center)

THIS FORM SHOULD BE FILLED UP DURING THE FIRST HEALTH FACILITY VISIT

Name Age.....years.....months.....days.....
Mother's Name Contact Number:
Date of Birth:..... Date of Report:
ID # Sex ☐ Male ☐ Female
Address.....

I. Neonatal High Risk Factors

Risk Factors	No	Yes
a. Was the birth weight<1,500grams?		
b. Did the child cry right after birth?		
c. Did the child stay at the hospital more than 5 days after birth?		
d. Was the child yellowish a few days after birth?		
e. Any defects of the head and neck?		
f. Is there a family history of deafness?		

II. Maternal Concern (Primary)

Does your child respond to loud sounds? ☐ Yes ☐ No

III. Health Care Concern (Primary)

Does your child respond to loud sounds? ☐ Yes ☐ No

*ANY YES ANSWER ON **PART I-III**, INFANT SHOULD BE REFERRED TO SECONDARY CENTER WITHIN FOUR WEEKS.

Filled up by:

Signature over Printed Name

Designation

Name of Health facility and address

APPENDIX G

UNHS High Risk Questionnaires For Community-Based Facilities* Level 2 Questionnaire



Universal Newborn Hearing Screening Community-Based Program

Questionnaire for Screening Congenital Hearing Impairment (Secondary Center)

Name Age years months days
 Mother's Name Contact Number:
 Date of Birth: Date of Report:
 ID # Sex ☐ Male ☐ Female
 Address:

Birth History

Rank of child
 Mode of delivery ☐ Normal ☐ Caesarian ☐ Vacuum extraction ☐ Forceps
☐ Others
 Gestational age weeks ☐ Full term ☐ Premature/ x
 Apgar scores at 1,5,10 minutes +,,
 Birth weight grams

Complications during pregnancy:

☐ None
☐ Bleeding ☐ Infection ☐ Diabetes ☐ Trauma ☐ Drugs
☐ Hypertension/toxaemia ☐ Premature labor ☐ Prolonged labor ☐ Rashes & Fever

Risk Factors	No	Yes
a. Birth weight <1500 grams		
b. Apgar score of <5 in five minutes		
c. History of NICU admission for 48 hours		
d. History of mechanical ventilation use > 5 days		
e. History of bacterial meningitis/ neonatal sepsis		
f. Administration of ototoxic drugs e.g. gentamicin		
g. Congenital infections (TORCH)		
h. Hyperbilirubinemia requiring exchange transfusion		
i. Defects of the head and neck		
j. Features and other findings associated with hearing loss		
k. Family history of permanent hearing loss in childhood		

*Based from JCIH 2007 High Risk Criteria

ANY YES ANSWER or OAE REFER, INFANT SHOULD BE REFERRED TO TERTIARY
CENTER WITHIN FOUR WEEKS.

Signature over Printed Name

Designation

Name of Health Facility and address

APPENDIX H

Department of Health Classification of Hospitals and Other Health Facilities

CLASSIFICATION OF HOSPITALS			
GENERAL	LEVEL 1	LEVEL 2	LEVEL 3
Clinical Services and Facilities for In-Patients	Consulting Specialists in: Medicine Pediatrics OB-Gyne Surgery	Level 1 plus all	Level 2 plus all:
		Departmentalized Clinical Services	Teaching/training with accredited residency training program in the 4 major clinical services
	Emergency and Out-patient Services	Respiratory Unit	Physical Medicine and Rehabilitation Unit
	Isolation Facilities	General ICU	
	Surgical/Maternity Facilities	High Risk Pregnancy Unit	Ambulatory Surgical Clinic
	Dental Clinic	NICU	Dialysis Clinic
Ancillary Services	Secondary Clinical Laboratory	Tertiary Clinical Laboratory	Tertiary lab with histopathology
	Blood Station	Blood Station	Blood Bank
	1 st Level X-ray	2 nd Level X-ray	3 rd level X-ray
	Pharmacy		

CLASSIFICATION OF OTHER HEALTH FACILITIES			
A	B	C	D
Primary Care Facility	Custodial Care Facility	Diagnostic/Therapeutic Facility	Specialized Out-patient Facility
With In-patient Beds: • Infirmary/Dispensary • Birthing Home	Psychiatric Care Facility	Laboratories • Clinical Lab/HIV • Blood Service Facilities • Drug Test Lab • NB Screening Lab • Water Lab	Dialysis Clinic (DC)
			Ambulatory Surgical Clinic (ASC)
Without Beds: • Medical Out-patient Clinics • OFW Clinics • Dental Clinics	Drug Abuse Treatment and Rehabilitation Center (DATRC)	Ionizing Machines as X-ray, CT Scan, mammography and others	In-Vitro Fertilization (IVF) Centers
	Sanitarium/Leprosarium	Non-Ionizing Machines as ultrasound, MRI and others	Radiation Oncology Facility
	Nursing Home	Nuclear Medicine	Oncology Center/Clinic

APPENDIX I

Risk Indicators Associated With Permanent Congenital, Delayed-Onset, or Progressive Hearing Loss in Childhood

(Joint Committee on Infant Hearing 2007 AAP, AAOHNS, ASHA)

1. Caregiver concern regarding hearing, speech, language, or developmental delay.
2. Family history of permanent childhood hearing loss.
3. Neonatal intensive care of >5 days, or any of the following regardless of length of stay: ECMO, assisted ventilation, exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix), and hyperbilirubinemia requiring exchange transfusion.
4. In-utero infections, such as CMV, herpes, rubella, syphilis, and toxoplasmosis.
5. Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies .
6. Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss.
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss, such as neurofibromatosis, osteopetrosis, and Usher syndrome Other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson
8. Neurodegenerative disorders, ¹ such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome.
9. Culture-positive postnatal infections associated with sensorineural hearing loss, including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis.
10. Head trauma, especially basal skull/temporal bone fracture requiring hospitalization.
11. Chemotherapy

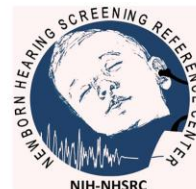
APPENDIX J

Form A: Application for Form for Device Certification

Form A-213 Page 1/1

Newborn Hearing Screening Reference Center

National Institutes of Health, UP Manila, Ermita, Manila



APPLICATION FORM

NEWBORN HEARING DEVICE

Name: _____

SURNAME

FIRST NAME

MIDDLE NAME

Company / Institution Name:

Company / Institution Name: _____
Address: _____

Phone: () _____ Cellphone: _____ Fax: () _____

Email: _____ **Website:** _____

DEVICE APPLIED FOR:

- ☐ Transient Evoked Otoacoustic Emissions (TEOAE)
- ☐ Distortion Product Otoacoustic Emissions(DPOAE)
- ☐ Capable both TEOAE and DPOAE
- ☐ Automated Auditory Brainstem Response (AABR)
- ☐ Capable all TEOAE, DPOAE and AABR

MODEL NAME: _____

MODEL NUMBER: _____

MANUFACTURER: _____

ADDRESS OF MANUFACTURER: _____

DATE RELEASED: _____

LOCAL DISTRIBUTOR: _____

ADDRESS OF DISTRIBUTOR: _____

CONTACT NUMBER OF DISTRIBUTOR: _____

EMAIL OF DISTRIBUTOR: _____

FOR NHSRC ONLY:

Application Received by: _____ Date of Application: _____

Date of Application: _____

Signature of Recipient: _____

Fee paid: P_____ (OR _____) Date of OR: _____

Result of Evaluation: ☐PASS ☐FAIL Reason: _____

Formal Report Received by: _____ Date: _____

Date Certificate issued: _____ **Certificate Received by:** _____ **Date:** _____

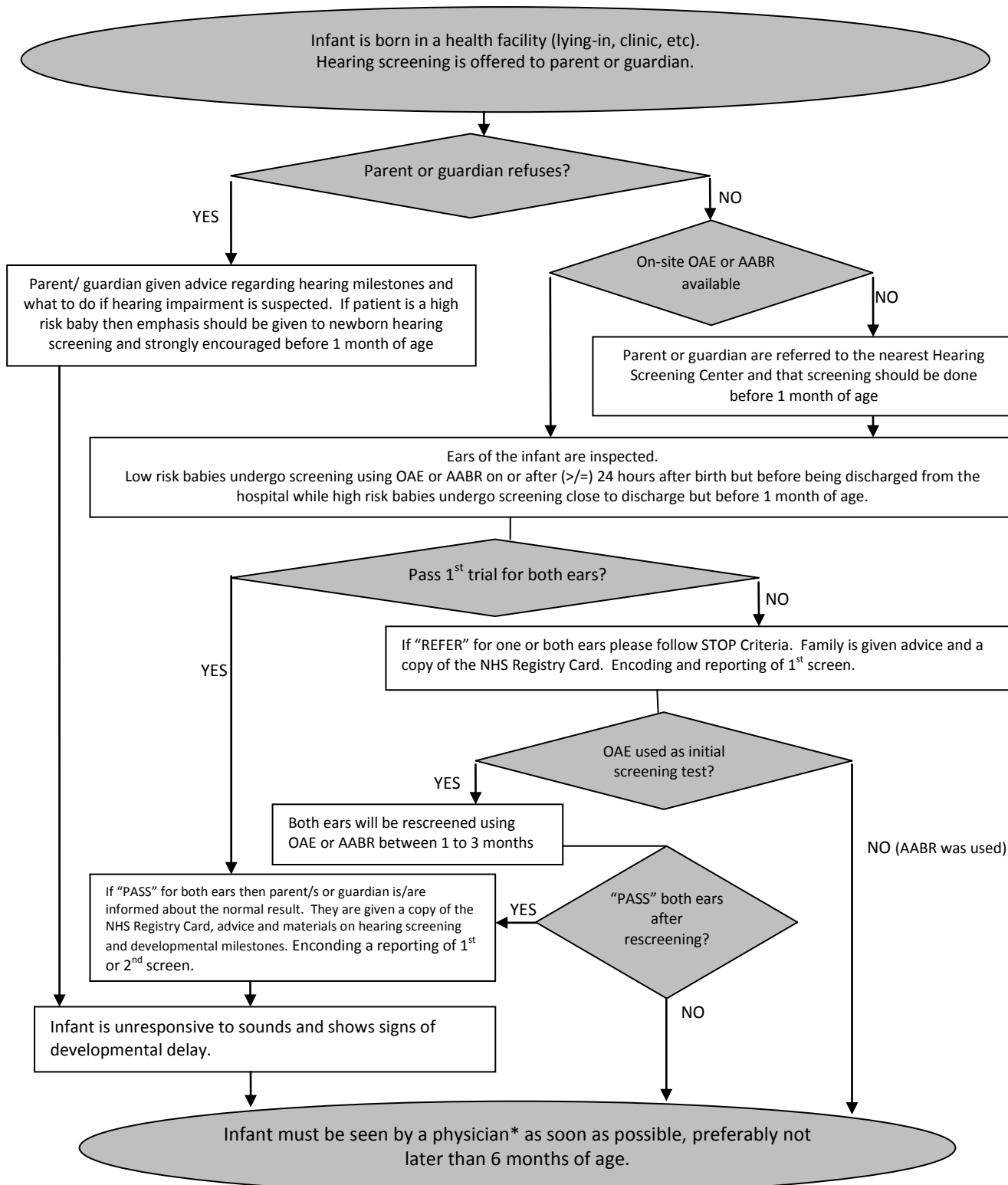
Name of Evaluators: 1 _____ Signature: _____

2 _____ Signature: _____

3 _____ Signature: _____

APPENDIX K

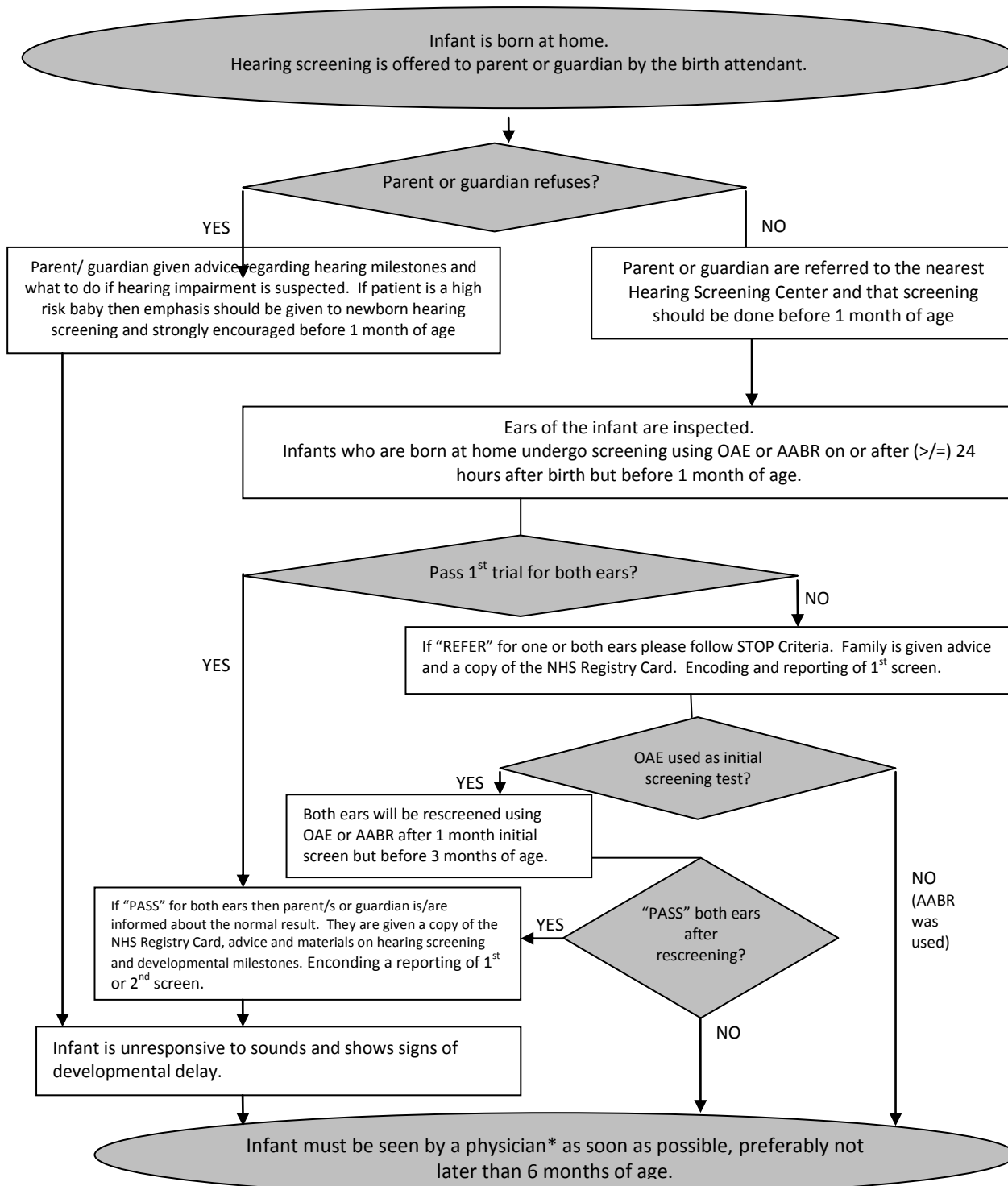
Newborn Hearing Screening Algorithm for Facility Born Babies



**Infant is examined by a physician and may order definitive hearing tests such as ABR and/or ASSR and/or behavioral audiometry. Depending on the result/s, the ENT gives a diagnosis and may recommend close follow-up, hearing amplification, further imaging techniques, surgery for hearing (cochlear implant, BAHA), or consult with a developmental pediatrician.*

APPENDIX L

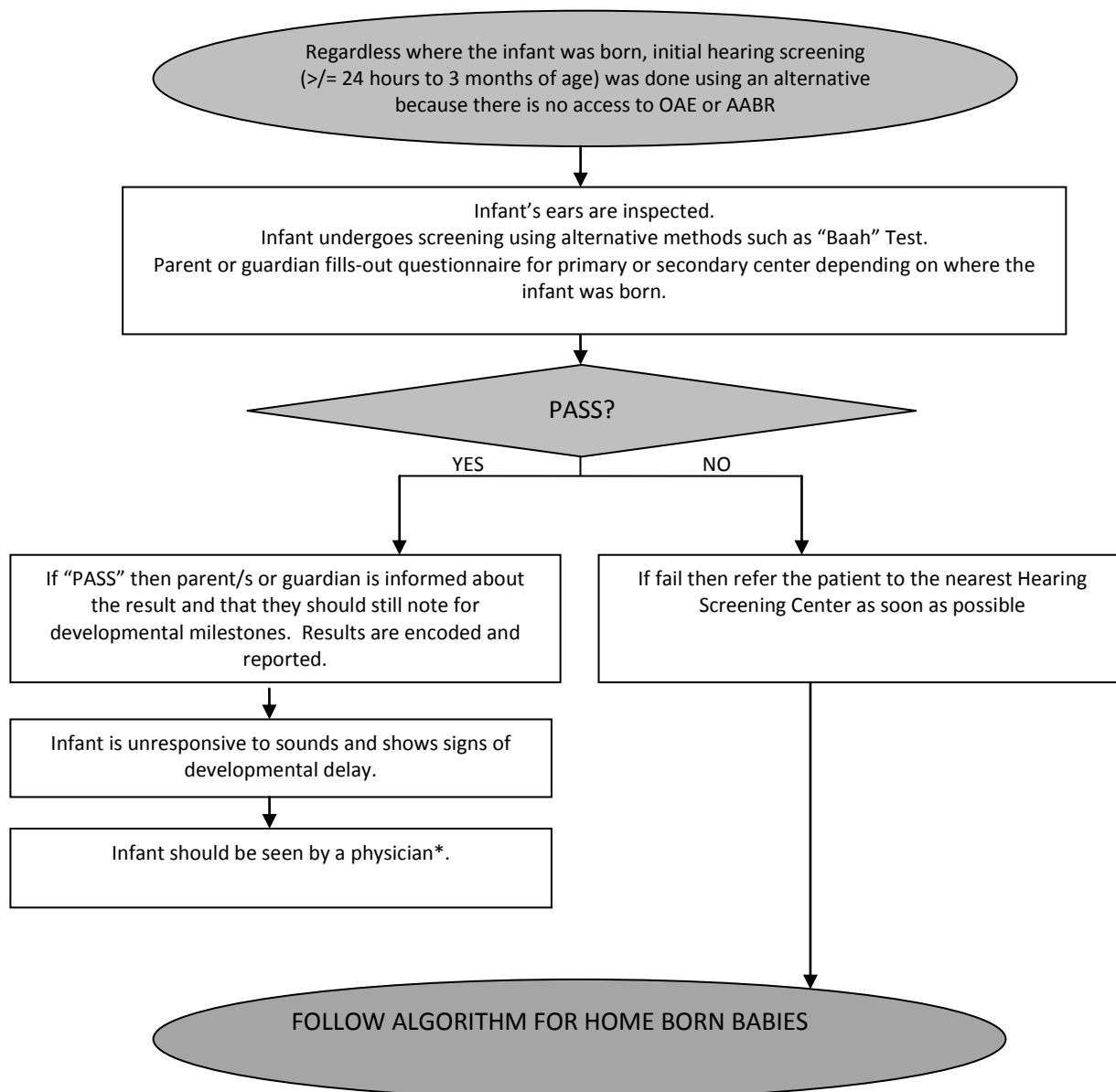
Newborn Hearing Screening Algorithm for Home Born Babies



**Infant is examined by a physician and may order definitive hearing tests such as ABR and/or ASSR and/or behavioral audiometry. Depending on the result/s, the ENT gives a diagnosis and may recommend close follow-up, hearing amplification, further imaging techniques, surgery for hearing (cochlear implant, BAHA), or consult with a developmental pediatrician.*

APPENDIX M

Newborn Hearing Screening Algorithm Using Alternative Methods



**Infant is examined by a physician and may order definitive hearing tests such as ABR and/or ASSR and/or behavioral audiometry. Depending on the result/s, the ENT gives a diagnosis and may recommend close follow-up, hearing amplification, further imaging techniques, surgery for hearing (cochlear implant, BAHA), or consult with a developmental pediatrician.*

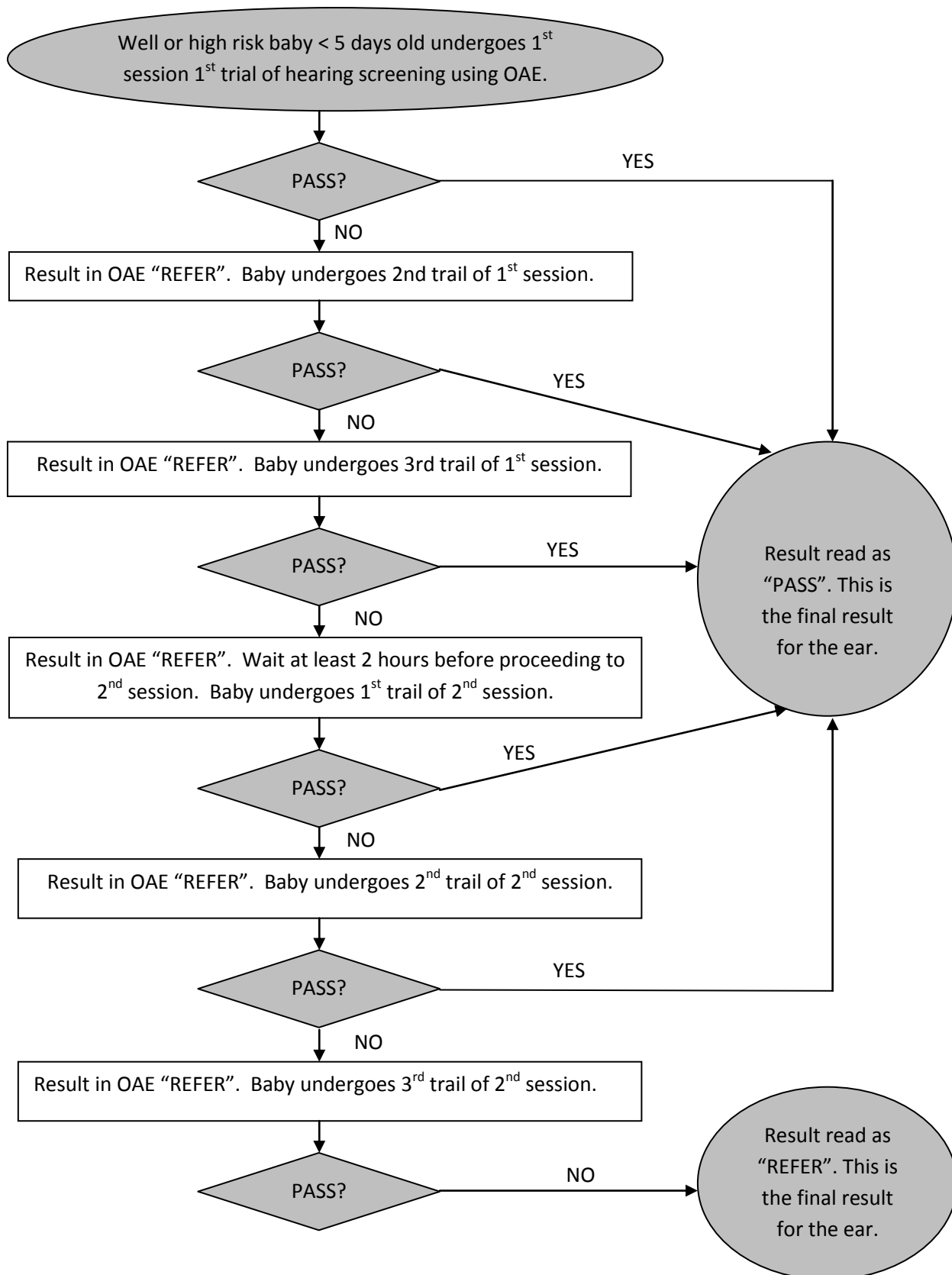
APPENDIX N

Milestones Related to Hearing

Birth to 3 months	<p>Reacts to loud sounds with startle reflex</p> <p>Is soothed and quieted by soft sounds</p> <p>Turns head to you when you speak</p> <p>Is awakened by loud voices and sounds</p> <p>Smiles in response to voices when spoken to</p> <p>Seems to know your voice and quiets down if crying</p>
3 to 6 months	<p>looks or turns toward a new sound</p> <p>responds to "no" and changes in tone of voice</p> <p>imitates his/her own voice</p> <p>enjoys rattles and other toys that make sounds</p> <p>begins to repeat sounds (such as ooh, aah, and ba-ba)</p> <p>becomes scared by a loud voice or noise</p>
6 to 10 months	<p>Responds to his/her own name, telephone ringing, someone's voice, even when not loud</p> <p>Knows words for common things (cup, shoe) and sayings ("bye-bye")</p> <p>Makes babbling sounds, even when alone</p> <p>Starts to respond to requests such as "come here"</p> <p>Looks at things or pictures when someone talks about them</p>
10 to 15 months	<p>Plays with own voice, enjoying the sound and feel of it</p> <p>Points toward or looks at familiar objects or people when asked to do so</p> <p>Imitates simple words and sounds; may use a few single words meaningfully</p> <p>Enjoys games like peek-a-boo and pat-a-cake</p> <p>Follows one step commands when shown by a gesture</p>
15 to 18 months	<p>Follows simple directions, such as "give me the ball" without being shown</p> <p>Uses words he/she has learned often</p> <p>Uses 2 to 3 word sentences to talk about and ask for things</p> <p>Knows 10 to 20 words</p> <p>Points to some body parts when asked</p>
18 to 24 months	<p>Understands simple "yes-no" questions (Are you hungry?)</p> <p>Understands simple phrases ("in the cup," "on the table")</p> <p>Enjoys being read to</p> <p>Points to pictures when asked</p>
24 to 36 months	<p>Understands "not now" and "no more"</p> <p>Chooses things by size (big, little)</p> <p>Follows two step commands, such as "get your shoes and come here"</p> <p>Understands many action words (run, jump)</p>

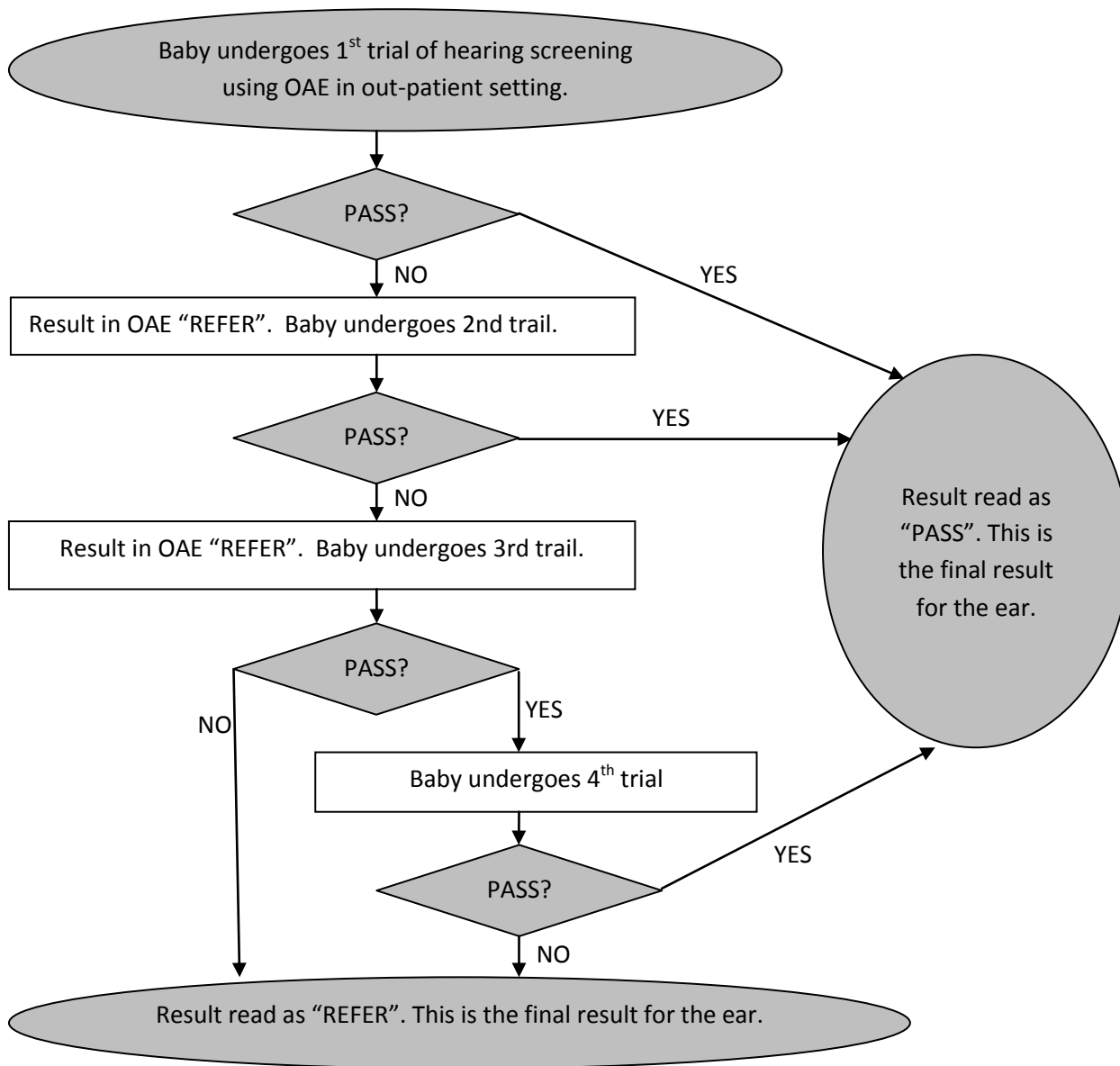
APPENDIX O

Stop Criteria Algorithm for Well Baby OAE and High Risk Baby <5 days Old



APPENDIX P

Stop Criteria Algorithm for OAE Outpatient Screening



APPENDIX Q

Sample of Newborn Hearing Screening Official Result (OAE or AABR)

Form No. _____			
NAME OF NEWBORN HEARING SCREENING CENTER <small>ADDRESS, CONTACT NO., EMAIL</small>			
OTOACOUSTIC EMISSIONS (OAE) OR AUTOMATED AUDITORY BRAINSTEM RESPONSE (AABR) Hearing Screening Results			
Name of Patient: _____		Age/Sex: _____	
Address & Tel. No.: _____		Date of Birth: _____	
Referring Doctor: _____		Date Tested: _____	
		NHSRC Registry No.: _____	

The hearing screening test was done using otoacoustic emissions (OAE) or automated auditory brainstem response test. Below are the results, please do not hesitate to get in touch with us if you have any question regarding the screening procedure or the results.

RIGHT EAR:

*** PASS**

X

****REFER**

LEFT EAR:

*** PASS**

X

****REFER**

OtoRead

OTOACOUSTIC EMISSIONS TEST

Right 08-May-03 05:16
DP 4 sec avg U7.61

NAME	F2	P1	P2	DP	NF	SN
2.0	66	55	7	-11	17	P
3.0	68	55	2	-19	21	P
4.0	64	54	3	-7	10	P

F2 + - - - - -

2.0 [|||||]

3.0 [|||||]

4.0 [|||||]

F2 + - - - - -

-15 -10 -5 0 5 10

Level (dB) ||-NF *-DP

Right : Pass

OtoRead

OTOACOUSTIC EMISSIONS TEST

Left 08-May-03 05:17
DP 4 sec avg U7.61

NAME	F2	P1	P2	DP	NF	SN
2.0	67	56	5	-2	7	P
3.0	65	54	6	-10	15	P
4.0	65	54	5	-20	26	P

F2 + - - - - -

2.0 [|||||]

3.0 [|||||]

4.0 [|||||]

F2 + - - - - -

-15 -10 -5 0 5 10

Level (dB) ||-NF *-DP

Left : Pass

COMMENTS: _____

***PASS:** Means that the hearing pathway from the ear canal to the cochlea is intact. This usually suggests normal development of speech and language unless there are other problems.

****REFER:** Means that further evaluation and testing is needed to make sure that there is no hearing impairment. Earwax or a baby who is very active during the test may lead to a 'REFER' result. We recommend a repeat screen in 1-3 months time.

PLEASE SHOW THE RESULTS TO YOUR PHYSICIAN. Even if your baby passed the test, your child's doctor will decide whether a re-screen is needed (if your child is high risk for hearing loss) or if further evaluation is required.

PLEASE BE ADVISED THAT IT IS IMPORTANT TO CONSULT YOUR CHILD'S DOCTOR IF THERE IS ANY CHANGE OR PROBLEMS REGARDING YOUR CHILD'S HEARING.

Consultant
Section of Audiology

Screener
(Signature Over Printed Name)

APPENDIX R

Sample of Newborn Hearing Screening Brochure (Filipino)


REPUBLIC ACT 9709

Ang lahat ng sanggol na ipinanganak sa Pilipinas ay dapat sumailalim sa HEARING SCREENING pagkasilang . . . bago magising buwan.

KAPAG MAY SUSPETA NA BINGI ANG BATA, HUWAG MAGATUBILI!

KOMUNSA SA DOKTOR O MAGTANONG SA PINAKAMALAPIT NA HEARING SCREENING CENTER.

HANAPIN ANG TATAK:



NEWBORN HEARING SCREENING REFERENCE CENTER


Address: 1st floor National Institutes of Health,
University of the Philippines Manila,
Pedro Gil Street, Ermita, Manila

Phone (02) 5158303

Cellphone 09236786041


Email nhsrhc.nih@gmail.com

Website www.newbornhearingscreening.ph



NHSRC
Newborn Hearing Screening Reference Center

Mommy, narinig na ba ni baby ang “I LOVE YOU” mo?



BAKIT KAILANGAN IPA-HEARING SCREENING SI BABY?

- Ang sanggol na ipinanganak na may kapansanan sa pandinig ay walang sintomas kaya't hindi agad nasusuri.
- Ang pandinig ay mahalaga para makapagsalita ang bata.
- Ang batang lumaking bingi ay mahihirapan sa pakikipagusap at pag-aaral.

PAANO MALALAMAN KUNG MAY PROBLEMA SA PANDINIG SI BABY?

Ang Otoacoustic Emissions (OAE) test o Automated Auditory Brainstem Response (AABR) test ay maaaring gamitin na screening tests. Ang mga test na ito ay mabilis (5-10 minuto) at walang nalalamang dulot na pinsala sa sanggol. Kailangan lamang ay tahimik at hindi gumagalaw ang sanggol upang lapat ang ear plug ng instrumento. Ito ay ginagawa sa tahimik na kuwarto o sa kuwarto mismo ng magina isang araw matapos ipinanganak ang sanggol.

PAANO KUNG HINDI PUMASA O REFER SA HEARING SCREENING SI BABY?

Kailangan ng karagdagang pagsusuri o confirmatory hearing test upang matiyak ang tunay na sanhi kung bakit hindi pumasa sa OAE o AABR test. Hinihikayat na sundin ang schedule na ito:

UNANG BUWAN
Hearing screening gamit ang OAE o AABR

1

PANGATLONG BUWAN
Hearing test na pangkumpirma

3

PANGANIM NA BUWAN
Maaang pagtugon sa pagkabingi ng bata (hearing aid, opera, o speech therapy)

6

PAANO KUNG PUMASA O PASS SA HEARING SCREENING SI BABY?

Hindi muna kailangan sumailalim sa confirmatory hearing test ang sanggol. Subalit, hindi nangangahulugang hindi maaaring matuklasang bingi o sadyang mabingi ang bata habang siya ay lumalaki.

Dapat pa rin subaybayan ang mga sumusunod na milestones sa paglaki ng bata:

0-3 BUWAN

- Nagugulat sa malalakas na tunog
- Tumatahimik sa mga pamilyar na boses

3-6 BUWAN

- Naghahanap ng tunog sa pamamagitan ng mata
- Nagisimulang gumawa ng sariling tunog o “babbling”
- Paglalaro gamit ang maiingay na laruan
- Pagtugon sa pagbabago ng tono ng boses

6-12 BUWAN

- Paglingon sa pinanggagalingan ng mahinang tunog
- Paggaya sa mga naririnig na salita
- Pagtugon sa pagtawag ng pangalan
- Nakakaintindi ng mga simpleng salita gaya ng “no” o “bye-bye”

12 BUWAN PATAAS

- Malinaw na nasasabi ang “mama” o “dada”
- Pinaglalaruan ang sariling boses, kumakanta na may pakiramdam
- Pagturo at pagtingin sa pamilyar na mga bagay

Kapag may suspetsa na bingi ang bata, komunsulta agad sa doctor o pumunta sa pinakamalapit na Hearing Screening Center. Ang batang matuklasang bingi sa pagkabata ay may pagasa pang makarinig, magsalita, magaral, at mabuhay ng normal.

APPENDIX S

Sample of Newborn Hearing Screening Brochure (English)

REPUBLIC ACT 9709

All infants born in the Philippines should undergo HEARING SCREENING shortly after birth . . . before one month of age.

IF THERE IS DOUBT THAT A CHILD IS HARD AT HEARING, DO NOT DELAY! CONSULT A DOCTOR OR GO TO THE NEAREST HEARING SCREENING CENTER.

LOOK FOR THE SIGN:



NEWBORN HEARING SCREENING REFERENCE CENTER

Address: 1st floor National Institutes of Health,
University of the Philippines Manila,
Pedro Gil Street, Ermita, Manila

Phone (02) 5158303

Cellphone 09236786041

Email nhsrhc.nih@gmail.com

Website www.newbornhearingscreening.ph



Mommy, did baby hear you say "I LOVE YOU"?



WHY DOES BABY NEED TO UNDERGO HEARING SCREENING?

1. An infant born with hearing impairment does not show obvious symptoms.
2. Hearing is important so that a child will be able to talk.
3. A child who grows up deaf will have difficulty in speaking and learning.

HOW DO WE KNOW IF BABY HAS A HEARING PROBLEM?

Otoacoustic Emissions (OAE) test or Automated Auditory Brainstem Response (AABR) test may be used as screening tests. These tests are fast to perform (5-10 minutes) and they have no known harmful effects. All are needed are a silent environment and calm quiet infant so that the earplug of the instrument will become fit. It is done in a quiet room or inside the room of the mother and child one day after an infant is born.

WHAT IF THE RESULT OF BABY'S HEARING SCREENING TEST IS **REFER**?

Additional testing or confirmatory hearing test is needed to find out why the infant failed the OAE or AABR test. This is also done to determine the cause of hearing loss. We recommend following the schedule:



WHAT IF THE RESULT OF BABY'S HEARING SCREENING TEST IS **PASS**?

No further confirmatory hearing test is need for the moment. However, it does not mean that the infant is not hard at hearing or may become hard at hearing while he/she is growing-up.

The following milestones should be noted while the child is growing-up:

0-3 MONTHS

- Startled when hearing a loud noise
- Soothed and quieted when hearing familiar voices or soft sounds

3-6 MONTHS

- Looks or turns toward sound
- Begins to repeat sounds or "babbling"
- Enjoys playing rattles and toys that make sounds
- Responds to changes in tone of voice

6-12 MONTHS

- Responds to sounds even when not loud
- Imitates simple words and sounds
- Responds to name calling
- Knows common words or things such as "bye-bye"


12 MONTHS AND ABOVE

- Can clearly say "mama" and "papa"
- Plays with own voice, enjoys sounds and feels it
- Point toward or looks at familiar objects

If there is doubt that a child is hard at hearing then consult a doctor immediately or go to the nearest Hearing Screening Center. A child diagnosed with hearing impairment at an early age might still have a chance to hear, speak, learn and live normally.

APPENDIX T

Newborn Hearing Screening Registry Form

NEWBORN HEARING SCREENING		PATIENT CODE	FACILITY CODE
HEARING SCREENING CENTER Name: _____ Address: _____ <hr/> PHILHEALTH: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF BIRTH: M / M / D / Y Y Y TIME OF BIRTH: pm/am BIRTH ORDER: _____ GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female NAME OF INFANT (if available): _____ NAME OF MOTHER: _____ ADDRESS: Last Name _____ First name _____ Middle name _____ House Number _____ Village / Barangay _____ City _____ Province _____ PHONE: () _____ PHYSICIAN/DOCTOR: _____		BIRTH WEIGHT: _____ grams GESTATION AGE: _____ weeks RISK FACTORS FOR HEARING LOSS: <input type="checkbox"/> 1 Hyperbilirubinemia requiring transfusion <input type="checkbox"/> 2 Ventilation > 48 hours <input type="checkbox"/> 3 NICU admission > 48 hours <input type="checkbox"/> 4 Ototoxic medication <input type="checkbox"/> 5 Family history of permanent childhood hearing loss <input type="checkbox"/> 6 Craniofacial anomalies with deformed pinna or ear canal <input type="checkbox"/> 7 Features associated with syndrome? <input type="checkbox"/> 8 In-utero infections? <input type="checkbox"/> 0 NONE SCREENER NAME: _____ SIGNATURE: _____  REGISTRY CARD NO: A0000000001	
DATE OF SCREENING: M / M / D / Y Y Y TYPE OF SCREENING: <input type="checkbox"/> Initial <input type="checkbox"/> Rescreen: METHOD OF SCREENING: <input type="checkbox"/> OAE <input type="checkbox"/> AABR <input type="checkbox"/> Others: RESULT: <input type="checkbox"/> PASS <input type="checkbox"/> REFER <input type="checkbox"/> NOT PERFORMED RIGHT: <input type="checkbox"/> LEFT: <input type="checkbox"/>			

APPENDIX U

Application Form for Newborn Hearing Screening Center Personnel

Form B-213 Page 1/2

Newborn Hearing Screening Reference Center
National Institutes of Health, UP Manila, Ermita, Manila



APPLICATION FORM
CERTIFYING WORKSHOP ON NEWBORN HEARING SCREENING

Name: _____
SURNAME FIRST NAME MIDDLE NAME

Birthday: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female
MONTH DAY YEAR

Home Address: _____ **Home phone ()** _____
Cellphone: _____

Work Address: _____ **Work phone: ()** _____
Fax: () _____

Email: _____

VALID IDENTIFICATION PRESENTED: _____
**If manager, must present valid PRC ID if physician or diploma in Masters in Audiology if Audiologist*

CERTIFICATION CATEGORY:

☐ **A Newborn Hearing Screening Center** ☐ Manager ☐ Screener
☐ **B Newborn Hearing Diagnostic Center** ☐ Manager ☐ Audiologist ☐ Screener
☐ **C Newborn Hearing Diagnostic and Intervention Center** ☐ Manager ☐ Audiologist ☐ Screener
☐ **D Newborn Hearing Diagnostic, Intervention, Surgical and Rehabilitation Center**
☐ ENT Coordinator ☐ Implant Surgeon ☐ Audiologist ☐ Speech Therapist ☐ Other Doctor: _____
☐ Screener

EDUCATION: (DO NOT WRITE ON-GOING OR UNFINISHED STUDIES)

LEVEL	INSTITUTION / SCHOOL AND ADDRESS	YEAR FINISHED	CERTIFIED TRUE COPY SUBMITTED (Checked by NHSRC)
High School			<input type="checkbox"/>
College			<input type="checkbox"/>
Post-graduate (MD)			<input type="checkbox"/>
Masters			<input type="checkbox"/>
Doctoral (PhD)			<input type="checkbox"/>
Other Diplomas, Certificates, Training			<input type="checkbox"/>

WORK / PROFESSIONAL EXPERIENCE: (May attach additional sheets)

	POSITION	INSTITUTION / COMPANY AND ADDRESS	INCLUSIVE DATES	CERTIFICATION OF EMPLOYMENT SUBMITTED (Checked by NHSRC)
Current				<input type="checkbox"/>
				<input type="checkbox"/>
Previous				<input type="checkbox"/>
				<input type="checkbox"/>

Form B-213 Page 2/2

Name: _____
SURNAME FIRST NAME MIDDLE NAME

FOR NHSRC ONLY:

Application Received by: _____ **Date of Application:** _____

Signature of Recipient: _____ **Fee paid: P (OR)** _____

Date of Workshop: _____ **Date of OR:** _____

Venue of Workshop: _____

Result of Workshop: ☐ PASS ☐ FAIL

Date Certificate issued: _____

Name of Workshop Coordinator: _____

Signature of Workshop Coordinator: _____

APPENDIX V

Application Form for Newborn Hearing Screening Center

Form C-213 Page 1/4

Newborn Hearing Screening Reference Center
National Institutes of Health, UP Manila, Ermita, Manila

APPLICATION FORM
Newborn Hearing Screening Center Licensing

Name of Manager: _____
SURNAME FIRST NAME MIDDLE NAME

Birthdate: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Home Address: _____ **Home phone (): _____**

Work Address: _____ **Cellphone: _____**

Position: _____ **Work phone: (): _____**

Address of Proposed Newborn Hearing Screening Center: _____ **Email: _____**

CATEGORY APPLIED FOR:

☐ A Newborn Hearing Screening Center
☐ B Newborn Hearing Diagnostic Center
☐ C Newborn Hearing Diagnostic and Intervention Center
☐ D Newborn Hearing Diagnostic, Intervention, Surgical and Rehabilitation Center

CATEGORY	REQUIREMENTS	NAME AND SIGNATURE OF DOH	NAME AND SIGNATURE OF NHSRC
A	<input type="checkbox"/> Category A NHS Certifying Course certificate of manager NAME: _____ <input type="checkbox"/> Optional Category A NHS Certifying Course certificate of personnel NAME: _____ <input type="checkbox"/> Area of at least 3 x 3 sq. meters with ambient sound not greater than (s) 40 dB <input type="checkbox"/> Otoacoustic emission test machine (either a transient-evoked or distortion product type) and/or an Automated Audiometric Brainstem Response (AABR) Test Machine <input type="checkbox"/> Access to a computer with internet, spreadsheet program (MS Excel Open Office), scanner, camera OR any data capture device capable of electronic transmission (QR code reader) <input type="checkbox"/> Hard and soft copies of official results <input type="checkbox"/> OAE <input type="checkbox"/> AABR <input type="checkbox"/> ABR <input type="checkbox"/> ASSR <input type="checkbox"/> Tympanometry <input type="checkbox"/> Play Audiometry <input type="checkbox"/> Behavioral Tests (VROA, etc.) <input type="checkbox"/> Hard and soft copy of advisory brochure given to parent <input type="checkbox"/> Refusal Form <input type="checkbox"/> BIR Certificate of Registration <input type="checkbox"/> Receipt <input type="checkbox"/> Business permit <input type="checkbox"/> DOH Facility Code		

Form C-213 Page 2/4

B

☐ Category A NHS Certifying Course certificate of manager
NAME: _____
☐ Category A NHS Certifying Course certificate of audiologist and/or PSO-HNS fellow
NAME: _____
☐ Masters in Audiology Diploma of audiologist or PANORS ABR Reading Course Certificate of PSO-HNS fellow
NAME: _____
☐ Optional Category A NHS Certifying Course certificate of personnel
NAME: _____
☐ Area of at least 3 x 5 sq. meters with ambient sound not greater than (s) 40 dB
☐ Otoacoustic emission test machine (either a transient-evoked or distortion product type) and/or an Automated Audiometric Brainstem Response (AABR) Test Machine
☐ Auditory Brainstem Response (ABR)
☐ AND / OR Auditory Steady State Response (ASSR)
☐ Immittance Machine (Tympanometer)
☐ Clinical audiometer with play audiometry capability
☐ Soundproof booth (<= 20 dB)
☐ Toys
☐ Reinforcers
☐ Access to a computer with internet, spreadsheet program (MS Excel Open Office), scanner, camera OR any data capture device capable of electronic transmission (QR code reader)
☐ Hard and soft copies of official results
☐ OAE
☐ AABR
☐ ABR
☐ ASSR
☐ Tympanometry
☐ Play Audiometry
☐ Behavioral Tests (VROA, etc.)
☐ Hard and soft copy of advisory brochure to be given to parent
☐ Refusal Form
☐ BIR Certificate of Registration
☐ Receipt
☐ Business permit
☐ DOH Facility Code

C

☐ Category A NHS Certifying Course certificate of manager
NAME: _____
☐ Category A NHS Certifying Course certificate of audiologist and/or PSO-HNS fellow
NAME: _____
☐ Masters in Audiology Diploma of audiologist or PANORS ABR Reading Course Certificate of PSO-HNS fellow
NAME: _____
☐ Optional Category A NHS Certifying Course certificate of personnel
NAME: _____
☐ Area of at least 3 x 5 sq. meters with ambient sound not greater than (s) 40 dB
☐ Otoacoustic emission test machine (either a transient-evoked or distortion product type) and/or an Automated Audiometric Brainstem Response (AABR) Test Machine
☐ Auditory Brainstem Response (ABR)

Form C-213 Page 3/4

C

☐ AND / OR Auditory Steady State Response (ASSR)
☐ Immittance Machine (Tympanometer)
☐ Clinical audiometer with play audiometry capability
☐ Soundproof booth (<= 20 dB)
☐ Toys
☐ Reinforcers
☐ Hearing aid fitting equipment
☐ Access to a computer with internet, spreadsheet program (MS Excel Open Office), scanner, camera OR any data capture device capable of electronic transmission (QR code reader)
☐ Hard and soft copies of official results
☐ OAE
☐ AABR
☐ ABR
☐ ASSR
☐ Tympanometry
☐ Play Audiometry
☐ Behavioral Tests (VROA, etc.)
☐ Hard and soft copy of advise brochure to be given to parent / guardian
☐ Refusal Form
☐ BIR Certificate of Registration
☐ Receipt
☐ Business permit
☐ DOH Facility Code

D

☐ Category A NHS Certifying Course certificate of manager
NAME: _____
☐ Category A NHS Certifying Course certificate of audiologist and/or PSO-HNS fellow
NAME: _____
☐ Masters in Audiology Diploma of audiologist or PANORS ABR Reading Course Certificate of PSO-HNS fellow
NAME: _____
☐ Optional Category A NHS Certifying Course certificate of personnel
NAME: _____
☐ Otorhinolaryngologist (ENT) Coordinator
NAME: _____
☐ PRC license
☐ Residency certificate in Otorhinolaryngology
☐ Fellowship certificate from Philippine Society of Otolaryngology Head and Neck Surgery
☐ Otorhinolaryngologist (ENT) Implant Surgeon
NAME: _____
☐ PRC license
☐ Residency certificate in Otorhinolaryngology
☐ Fellowship certificate from Philippine Society of Otolaryngology Head and Neck Surgery
☐ Implant Surgery Certificate
☐ Other Specialized Doctors: _____
NAME: _____
☐ PRC license
☐ Residency certificate: _____
☐ Fellowship certificate: _____
☐ Diploma of Speech therapist / occupational therapist
NAME: _____
☐ Diploma
☐ Area of at least 3 x 5 sq. meters with ambient sound not greater than (s) 40 dB

Form C-213 Page 4/4

D

☐ Otoacoustic emission test machine (either a transient-evoked or distortion product type) and/or an Automated Audiometric Brainstem Response (AABR) Test Machine
☐ Auditory Brainstem Response (ABR)
☐ AND / OR Auditory Steady State Response (ASSR)
☐ Immittance Machine (Tympanometer)
☐ Clinical audiometer with play audiometry capability
☐ Soundproof booth (<= 20 dB)
☐ Toys
☐ Reinforcers
☐ Hearing aid fitting equipment
☐ Access to a computer with internet, spreadsheet program (MS Excel Open Office), scanner, camera OR any data capture device capable of electronic transmission (QR code reader)
☐ Hard and soft copies of official results
☐ OAE
☐ AABR
☐ ABR
☐ ASSR
☐ Tympanometry
☐ Play Audiometry
☐ Behavioral Tests (VROA, etc.)
☐ Hard and soft copy of advisory brochure to be given to parent
☐ Refusal Form
☐ BIR Certificate of Registration
☐ Receipt
☐ Business permit
☐ DOH Facility Code

FOR NHSRC ONLY:

Application Received by: _____ Date Received by NHSRC: _____

Signature of Recipient: _____

Date Forwarded to DOH: _____

Name NHSRC assigned: _____

Address NHSRC assigned: _____

Work phone NHSRC assigned: _____ Cellphone: _____ Email: _____

FOR DOH ONLY:

Application Received by: _____ Date Received by DOH: _____

Signature of Recipient: _____

Date of On-site inspection: _____

Fee paid: _____ OR Number: _____ Date Paid: _____

Date of on-site inspection: _____

Name DOH assigned: _____

Work phone DOH assigned: _____ Cellphone: _____ Email: _____

Name NHSRC assigned: _____

Address NHSRC assigned: _____

Work phone NHSRC assigned: _____ Cellphone: _____ Email: _____

STATUS: ☐ License issued Date issued: _____ Received by: _____

☐ License not issued Reason: _____