Department for Children and Families
Rehabilitation Services

Hearing Aid Provision

Client _____ Age _____
Address _____
City, Zip _____

Section Ia. Medical Examination

Physician Name _____
Address _____

Type of Loss:	Right	Left
Normal		
Sensori-neural		
Conductive		
Mixed		
Otologic Pathology	Right	Left
Impacted Cerumen		
Otitis External		
Secretory Otitis		
Otitis Media, acute		
Otitis Media, chronic		
Mastoiditis, chronic		
Cholesteatoma		
Otosclerosis		
Congenital Malformation		
Cochlear Lesion		
Other (specifiy):		
Case History	Yes	No
Hereditary hearing loss?		
Intelligible speech?		
Does patient speech read?		
Is patient legally blind?		
What is patient's primary mode of		
Comments:		

Diagnosis: _____
Prognosis: _____
Recommendation (Medical treatment, surgery, hearing aid(s), other). _____

_____
Signature of Physician Date

Counselor _____
Address _____
City, Zip _____

Section 1b. Hearing Examination

Audiologist Name _____
Address _____

Air Conduction Thresholds (dBHL)

kHz .25 .5 1 2 3 4 6 8
RE _____
LE _____

El Masking
RE _____
LE _____

Bone Conduction Thresholds (DBHL)

kHz .25 .5 1 2 3 4 6 8
RE _____
LE _____

El Masking
RE _____
LE _____

Speech Recognition Threshold (dBHL)

MLV _____ Tape Rec _____ CD Rec _____

Findings:				El Masking:			
SRT-AC	RE __	LE __		RE __	LE __		
SRT-BC	RE __	LE __		RE __	LE __		
SAT	RE __	LE __		RE __	LE __		
MCL	RE __	LE __					
UCL	RE __	LE __					

Word Discrimination Score (%)
MLV _____ Tape Rec _____ CD Rec _____
Test/Lists (RE/LE) _____

	dBHL	%Correct	El Masking
RE	_____	_____	_____
LE	_____	_____	_____

Test/Lists (RE/LE)

	dBHL	%Correct	El Masking
RE	_____	_____	_____
LE	_____	_____	_____

ANSI Audiometer used:
Make _____ Model _____ SN _____
Calibration date _____
Acoustic Immittance:

	Jerger-Type Tympanogram	Resting Pressure	Static Compliance
RE	_____	_____	_____
LE	_____	_____	_____

(if additional special testing is required, attach findings)

_____
Signature of Examiner Date

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Section II: Certification for Hearing Aid Dispensing (Hearing Aid Provider)

Client _____ Age _____ Counselor _____
Address _____ Address _____
City, Zip _____ City, Zip _____

Check One: MD _____ AUD _____ HA Dealer _____
Fitting Preference: Right Ear _____ Left Ear _____ Binaural _____
(circle) HA Technology Tier: RE I II III LE I II III BIN I II III

1. Specify the Make, Model and Type of recommended hearing aid(s) and optional features, e.g. noise reduction, circuitry, telecoil, etc.

   _____
   _____
   _____

2. Describe the client's needs and expected benefits of a hearing aid in this client's specific employment and in other situations. If Binaural aids are recommended, describe the client's needs, desire, and expected benefits.

   _____
   _____
   _____

3. If Tier III amplification is recommended above, a secondary hearing aid recommendation from Tier I or Tier II technology is required in the event that digitally programmable amplification is not authorized.

   _____
   _____
   _____

I certify the need for dispensing of a hearing aid(s) as recommended above, and in compliance with FDA regulations, I have advised the above named client to consult with a licensed physician (preferably an ear specialist) before the hearing aid is dispensed if the prospective user has any of the following eight conditions: 1) Visible congenital or traumatic deformity of the ear; 2) History of active drainage from the ear within the previous 90 days; 3) History of sudden or rapidly progressive hearing loss within the previous 90 days; 4) Acute or chronic dizziness; 5) unilateral hearing loss of sudden or recent onset within the previous 90 days; 6) Audiometric air-bone gap equal to or greater than 15 decibels at 500 Hz, 1,000 Hz and 2, 000 Hz; 7) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal; 8) Pain or discomfort in ear.

_____ _____
Hearing Aid Provider Signature Provider Number

_____ _____
Address Date

_____

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Section III. Hearing and Evaluation (Filled out after hearing and fitting.) Provide sound field unaided versus aided (monaural and/or binaural) results for the following audiometric tests in a sound attenuated room meeting current ANSI standards. For clients who are unable to be tested by conventional HAE methods, substitute other hearing aid assessment procedures (e.g., speech awareness thresholds, REM probe-tube microphone measurements, etc.) and attach test findings.

Client _____ Age _____ Counselor _____
Address _____ Address _____
City, Zip _____ City, Zip _____

Right Ear:
Make _____ Model _____ SN _____
RTG _____ SSPL90 _____
Aided SRT _____ dBHL Aided WDS _____ %
Unaided SRT _____ dBHL Unaided WDS _____ %
Aided Spch Tol _____ dBHL (circle) Technology Tier: I II III

Left Ear:
Make _____ Model _____ SN _____
RTG _____ SSPL90 _____
Aided SRT _____ dBHL Aided WDS _____ %
Unaided SRT _____ dBHL Unaided WDS _____ %
Aided Spch Tol _____ dBHL (circle) Technology Tier: I II III

Binaural: (Fill out only if binaural recommendation.) Use same hearing aids noted above for right and left.
Aided SRT _____ dBHL Aided WDS _____ %
Unaided SRT _____ dBHL Unaided WDS _____ %
Aided Spch Tol _____ dBHL

Above aided and unaided Word Discrimination Score Testing:
Presentation Level _____ dBHL
WDS Test _____
Lists: Right _____ Left _____ Binaural _____
Check one: MLV _____ Tape _____ CD _____

Attach or describe other HAE Information or Findings (e.g., REM): _____

_____

_____

_____

_____ _____
Print Name of Hearing Aid Provider HA License #

_____ _____
Hearing Aid Provider Signature Date

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Section IV. Client Hearing and Satisfaction Questionnaire

Within 30 days of the hearing aid fitting and to receive reimbursement, the hearing aid provider should submit the client satisfaction questionnaire (Section IV), the hearing aid evaluation (Section III), and the manufacturer invoice for the hearing aid to the rehabilitation counselor.

Client _____ Age _____ Counselor _____
Address _____ Address _____
City, Zip _____ City, Zip _____

1. The dispenser of your hearing aid was professional and courteous in providing services to you.
   Strongly agree _____ Agree _____ Neutral _____ Disagree _____ Strongly Disagree _____
   Comments _____

2. The dispenser considered your interests and needs in selecting your hearing aid(s).
   Strongly agree _____ Agree _____ Neutral _____ Disagree _____ Strongly Disagree _____
   Comments _____

3. The dispenser provided thorough information about how to operate and care for your hearing aid(s) and answered your questions.
   Strongly agree _____ Agree _____ Neutral _____ Disagree _____ Strongly Disagree _____
   Comments _____

4. The dispenser listened to your description of problems with your hearing aid and attempted to make adjustments.
   Strongly agree _____ Agree _____ Neutral _____ Disagree _____ Strongly Disagree _____
   Comments _____

5. Overall, would you say that you are satisfied with your hearing aid(s)?
   Strongly agree _____ Agree _____ Neutral _____ Disagree _____ Strongly Disagree _____
   Comments _____

6. If you were provided binaural hearing aids, do you wear both hearing aids most of the time? (Circle one)
   Yes No

   If no describe how often and under what circumstance you wear both hearing aids _____
   _____
   _____
   _____
   _____
   _____
   _____