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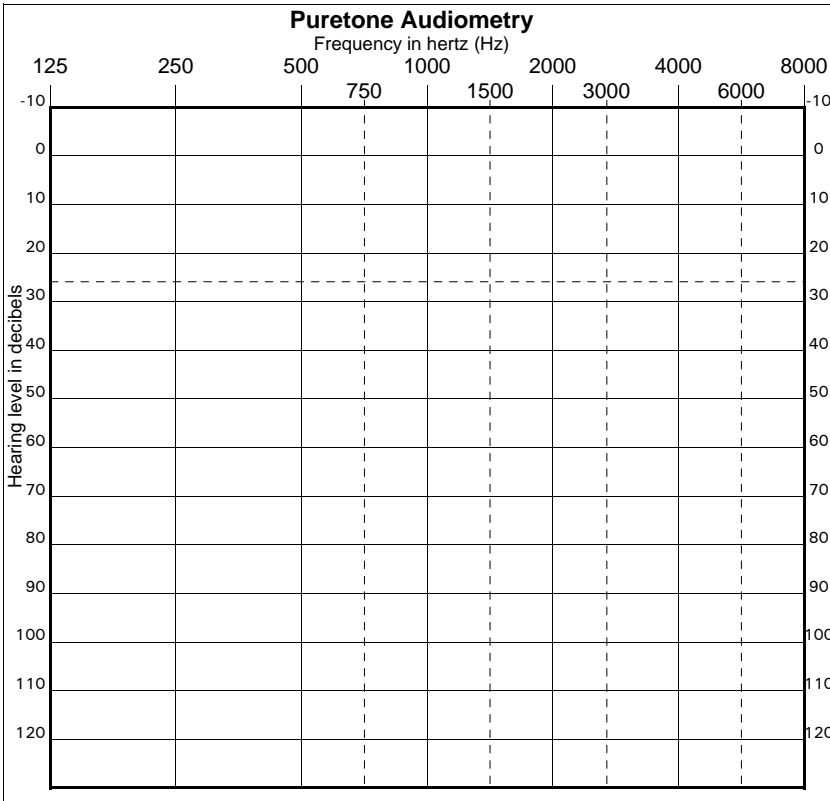
WCB Claim Number _____
Personal Health Number _____
Date of Birth (Year / Month / Day) _____

Client's (Surname) _____ (First Name) _____ (Initial) _____

Address Street _____ City/Town _____ Province _____

Postal Code _____ Telephone Number () _____ Is the client working? Yes No

Booking requested by _____ Date of Service (Year / Month / Day) _____

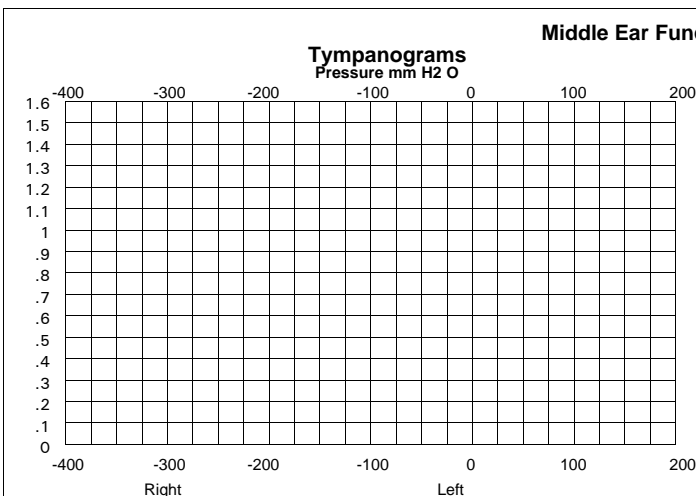


Speech Audiology

| | SRT | SAT | MASK | Word Recognition | | | | MCL | UCL |
|-----|-----|-----|------|------------------|-----|------|----|-----|-----|
| | | | | % | H L | MASK | IN | | |
| R | | | | | | | | | |
| L | | | | | | | | | |
| SF | | | | | | | | | |
| AID | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Speech Materials: _____ SRT/SDT DISCRIM: _____
MASK: _____ MLV REC
EST. Accuracy: _____
Insert Headphones Yes No

| Key | Air | | Bone | | No Response |
|-------|----------|--------|----------|--------|-------------|
| | Unmasked | Masked | Unmasked | Masked | |
| Right | ○ | △ | < | □ | ↘ |
| Left | × | □ | > | □ | ↙ |



Middle Ear Function

Acoustic Reflexes

| | Right | | Left | |
|---------|----------------|----------------|----------------|----------------|
| | Contra | IPSI | IPSI | Contra |
| | Tone R Probe L | Tone R Probe R | Tone L Probe L | Tone L Probe R |
| 500 Hz | | | | |
| 1000 Hz | | | | |
| 2000 Hz | | | | |
| 4000 Hz | | | | |

- Abbreviations**
- CNT: Did/Could Not Test
 - A: Aided
 - SAT: Speech Reception/Awareness Threshold
 - SF: Sound Field
 - MCL: Most Comfortable Loudness Level
 - UCL: Uncomfortable loudness Level
 - MLV: Monitored Live Voice
 - HL: Hearing Level
 - NBN: Narrow Band Noise
 - FM: Frequency Modulation
 - WNL: Within Normal Limits
 - CNM: Could Not Mask
 - NR: No Response
 - VIB: Vibrotactile

| Type | RIGHT | LEFT |
|-------------|-------|------|
| ME Pressure | | |
| Compliance | | |
| Volume | | |

Reflex Decay: 500 Hz negative/positive
1000Hz negative/positive

Client's Name: (Surname)

(Given Name)

(Initial)

Claim Number:

Background Information

Right (R) Left (L)

| | | |
|-----------------------|--------------------------|--------------------------|
| Hearing Difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| Tinnitus Intermittent | <input type="checkbox"/> | <input type="checkbox"/> |
| Tinnitus Constant | <input type="checkbox"/> | <input type="checkbox"/> |
| Pressure / Fullness | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Head Trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear Pain | <input type="checkbox"/> | <input type="checkbox"/> |

Current Hearing Aid Right Left

Style _____

Make _____

Model _____

Serial Number _____

Date Purchased _____

| | |
|--------------------------|--------------------------------------|
| <input type="checkbox"/> | Vertigo _____ |
| <input type="checkbox"/> | E.N.T. _____ |
| <input type="checkbox"/> | Infectious Diseases _____ |
| <input type="checkbox"/> | Congenital Difficulties _____ |
| <input type="checkbox"/> | Noise Exposure _____ |
| <input type="checkbox"/> | Ototoxic Medications _____ |
| <input type="checkbox"/> | Family History of Hearing Loss _____ |

Comments _____

Results

Degree of Hearing Loss

| R | L |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Normal (0-15 dBHL)

Minimal (16-25dBHL)

Mild (26-40 dBHL)

Moderate (41-55 dBHL)

Moderate-Severe (56-70 dBHL)

Severe (71-90 dBHL)

Profound (91+ dBHL)

Type of Hearing Loss

| R | L |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

High Frequency

Low Frequency

Conductive

Sensorineural

Mixed

Middle Ear Function

| R | L |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Normal Tympanogram

Negative Middle Ear Pressure

Flat/Rounded Tympanogram

High Compliance

Low Compliance

Absent/Elevated Acoustic Reflexes

Large Physical Volume

Recommendations

Family Physician Referral _____

Otologic (E.N.T.) Referral _____

Audiologic Reassessment After Medical Treatment _____

Reassessment: _____

Specialized Testing: _____

Other: _____

Hearing Conservation Measures

Hearing Aid Repair

Hearing Aid Trial

Auditory Brain Response (ABR)

Summary/Comments

Noise Induced Hearing Loss Package provided to worker. Date _____ (Year / Month / Day)

| | | |
|--|----------------------------|---|
| Assessment Completed by: <input type="checkbox"/> Initial Assessment (Audiologist only) (HL 01) <input type="checkbox"/> Subsequent Assessment (HL 02) | Skill Code: HEAR | Name and mailing address of service provider: (please print) |
| Print Name: | WCB Billing Number | |
| Signature: | Telephone Number () | |

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.