

**HEARING LOSS SERVICES
HEARING LOSS ASSESSMENT**

PLEASE COMPLETE ALL PAGES IN FULL

WCB Claim Number _____

Date of Birth (Year / Month / Day) _____

Telephone Number _____

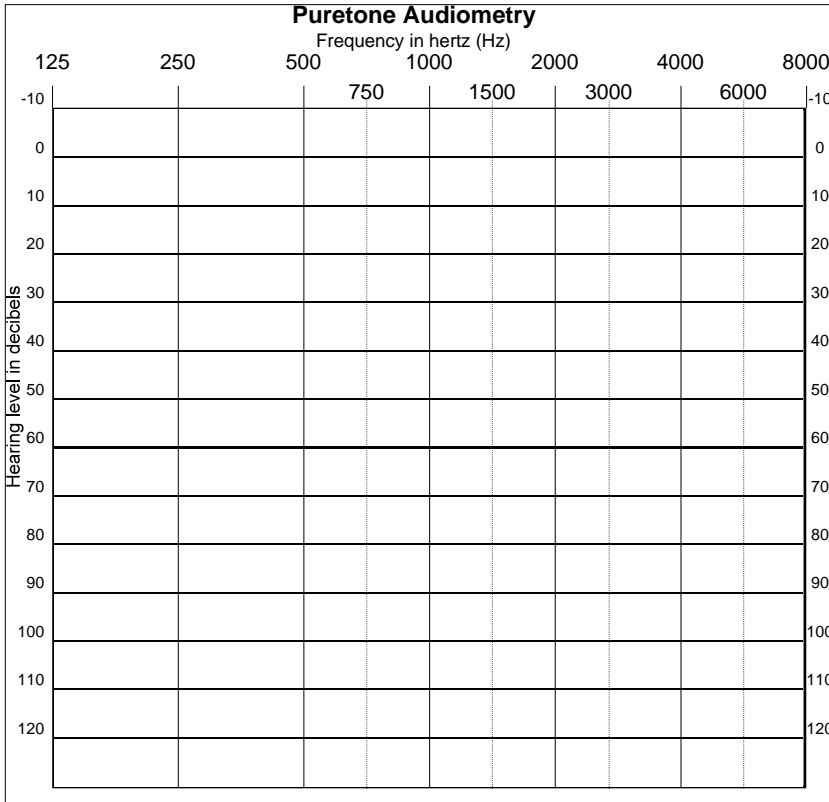
Date of Service (Year / Month / Day) _____

WORKER DETAILS

Surname _____ First Name and Initial _____

Address Street _____ City/Town _____ Province _____ Postal Code _____

Is the client working? Yes No Booking requested by _____



Speech Audiometry

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

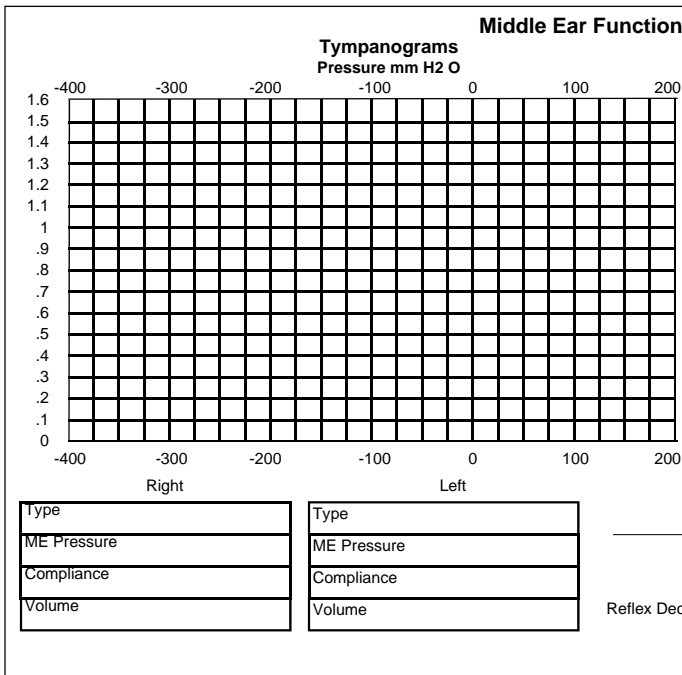
Speech Materials _____ SRT/SDT DISCRIM _____

MASK _____ MLV REC

EST. Accuracy: _____

Insert Headphones Yes No

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



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				

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

RIGHT LEFT

- Abbreviations**
- CNT: Did/Could Not Test
 - A: Aided
 - SAT: Speech Recaption/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

(Surname)	(First Name)	Claim Number:
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<p>Background Information</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align: center;">Right (R)</td> <td style="width:10%; text-align: center;">Left (L)</td> <td style="width:50%;"></td> </tr> <tr> <td>Hearing Difficulty</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Vertigo _____</td> </tr> <tr> <td>Tinnitus Intermittent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> E.N.T _____</td> </tr> <tr> <td>Tinnitus Constant</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Infectious Diseases _____</td> </tr> <tr> <td>Pressure / Fullness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Congenital Difficulties _____</td> </tr> <tr> <td>Ear Infections</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Noise Exposure _____</td> </tr> <tr> <td>Surgery</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Ototoxic Medications _____</td> </tr> <tr> <td>Head Trauma</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Family History of Hearing Loss _____</td> </tr> <tr> <td>Ear Pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> </table> <p>Current Hearing Aid <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p>Style _____</p> <p>Make _____</p> <p>Model _____</p> <p>Serial Number _____</p> <p>Date Purchased _____</p>		Right (R)	Left (L)		Hearing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Vertigo _____	Tinnitus Intermittent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> E.N.T _____	Tinnitus Constant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Infectious Diseases _____	Pressure / Fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Congenital Difficulties _____	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Noise Exposure _____	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ototoxic Medications _____	Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Family History of Hearing Loss _____	Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>		<p>Comments _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Results								
Degree of Hearing Loss	R	L	Type of Hearing Loss	R	L	Middle Ear Function	R	L
Normal (0-15 dBHL)	<input type="checkbox"/>	<input type="checkbox"/>	High Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Normal Tympanogram	<input type="checkbox"/>	<input type="checkbox"/>
Minimal (16-25dBHL)	<input type="checkbox"/>	<input type="checkbox"/>	Low Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Negative Middle Ear Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mild (26-40 dBHL)	<input type="checkbox"/>	<input type="checkbox"/>	Conductive	<input type="checkbox"/>	<input type="checkbox"/>	Flat/Rounded Tympanogram	<input type="checkbox"/>	<input type="checkbox"/>
Moderate (41-55 dBHL)	<input type="checkbox"/>	<input type="checkbox"/>	Sensorineural	<input type="checkbox"/>	<input type="checkbox"/>	High Compliance	<input type="checkbox"/>	<input type="checkbox"/>
Moderate-Severe (56-70 dBHL)	<input type="checkbox"/>	<input type="checkbox"/>	Mixed	<input type="checkbox"/>	<input type="checkbox"/>	Low Compliance	<input type="checkbox"/>	<input type="checkbox"/>
Severe (71-90 dBHL)	<input type="checkbox"/>	<input type="checkbox"/>				Absent/Elevated Acoustic Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Profound (91+ dBHL)	<input type="checkbox"/>	<input type="checkbox"/>				Large Physical Volume	<input type="checkbox"/>	<input type="checkbox"/>

Recommendations	
<input type="checkbox"/> Family Physician Referral _____ <input type="checkbox"/> Otologic (E.N.T.) Referral _____ <input type="checkbox"/> Audiologic Reassessment After Medical Treatment _____ <input type="checkbox"/> Reassessment: _____ <input type="checkbox"/> Specialized Testing: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hearing Conservation Measures <input type="checkbox"/> Hearing Aid Repair <input type="checkbox"/> Hearing Aid Trial <input type="checkbox"/> Auditory Brain Response (ABR)

Summary/Comments

<input type="checkbox"/> Noise Induced Hearing Loss Package provided to worker. Date _____ (Year / Month / Day)		
WCB Billing Number	Telephone Number	Assessment Completed by: Initial Assessment (HL 01) Initial Assessment - Audiologist (HL 01 AUD) Re-Assessment (HL 02) Re-Assessment Audiologist (HL 02 AUD)
Date of Service (Year / Month / Day)	Fax Number	
Name and mailing address of service provider: (please print)	Print Name:	
Invoice Number	Signature and Credentials:	

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