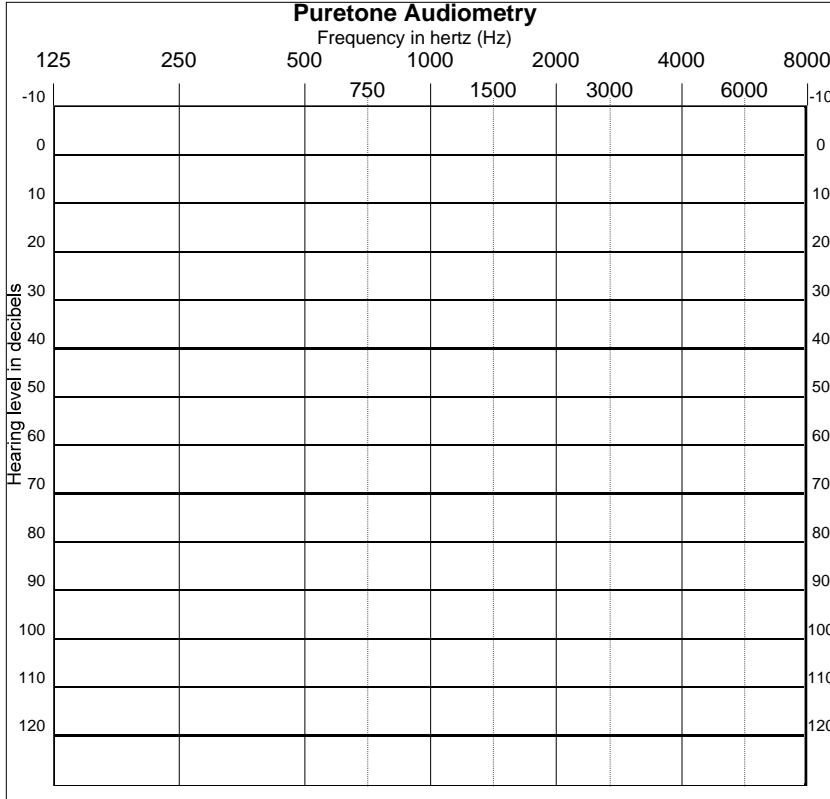


HEARING LOSS ASSESSMENT

Box 2415
Edmonton, Alberta T5J 2S5
Fax (780) 427-5863
1-800-661-1993

WCB Claim Number _____
Personal Health Number _____

Client's (Surname) _____ (First Name) _____ (Initial) _____ Date of Birth (Year / Month / Day) _____
Address Street _____ City/Town _____ Province _____
(Postal Code) _____ Telephone Number _____ Is the client working? Yes No
Booking requested by _____ Date of Service (Year / Month / Day) _____

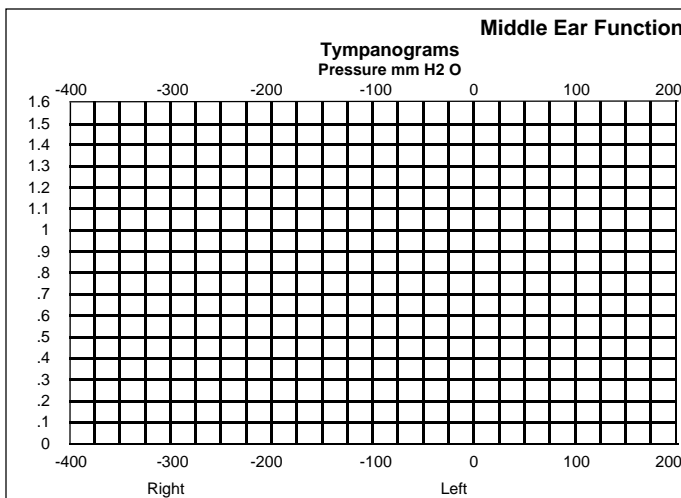


Speech Audiometry

	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				

- ### 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

Type	Type
ME Pressure	ME Pressure
Compliance	Compliance
Volume	Volume

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

Client's Name: <i>(Surname)</i>	<i>(Given Name)</i>	<i>(Initial)</i>	Claim Number:
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<p>Background Information</p> <table style="width:100%; border: none;"> <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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Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>																																			

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	Name and mailing address of service provider: (please print)
Date of Service _____ (Year / Month / Day)	Fax Number	
Assessment Completed by: <input type="checkbox"/> Initial Assessment (HL 01) <input type="checkbox"/> Subsequent Assessment (HL 02)	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.