Providence Health Care

Place Patient Form Label Here

PHC HEARING AID CHECK FORM FOR SEQUENTIAL COCHLEAR IMPLANT

Your patient has been referred for a sequential cochlear implant candidacy assessment at St. Paul's Hospital. In order to accurately determine your patients' candidacy, we must assess their speech understanding ability in the best-aided condition. Their hearing aid (and ear mold) must be optimally fit based on their current hearing levels.

Please complete the following form, attach the requested documents and return them to your patient. If you have any questions, please do not hesitate to contact us at 604-806-9616.

Your time and effort will allow us to provide the best care for our patients.

☐ Informed Consent Obtained

PATIENT INFORMATION	
Name: (last, first)	DOB: (dd/mmm/yyyy)
Address:	Phone:
City:	Email:
Postal Code:	

Right/Left Hearing Aid (Please indicate side of non-implanted ear: _____)	
Manufacturer	
Model	
Serial Number	
Fitting Date	

Please confirm that the following has all been completed:
☐ Current audiogram including word recognition scores (within 6 months)
☐ Cleaned and checked hearing aids
☐ Confirm appropriate fit of hearing aid (and ear mold)
☐ A program in the hearing aid to meet prescriptive targets *if* real ear targets are not met at user settings has been provided * This is important for candidacy assessment. Please indicate which program in hearing aid is set to prescriptive targets Program number: _____

See Over

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If real ear targets are not met in user settings program, please comment:
Please comment if you feel the patient could perform better with an alternative hearing aid, style or technology:
Please provide any additional information that may be relevant (e.g. consistent use of hearing aid):
Recommendations:

RAUD/RHIP: _____

Clinic Name: _____ Clinic Phone Number: _____

Signature: _____ Date: _____