HEARING AID CONSULTATION FORM

Patient Name: _____ **Audiological Evaluation Date:** _____

Audiologist: _____ **Fitting Date:** _____

Medical Clearance: Dr. _____ **Special Needs:** _____

Previous Hearing Aid History: _____

HEARING AID CONSULTATION: _____ **(date)**

☐ Hearing Aid Counseling/Selection
☐ Benefits/Warranty
☐ Trial Period
☐ Family/Caretaker participation (☐ NA)

HEARING AID FITTING: _____ **(date)**

	LEFT EAR	**RIGHT EAR**
Make:	_____	_____
Model:	_____	_____
Serial number:	_____	_____
Settings: (Conv.)	_____	(Conv.) _____
Programmable:	☐ Yes ☐ No	☐ Yes ☐ No
Earmold:	_____ ☐ NA	_____ ☐ NA

Information Discussed with Patient:

- ☐ Discuss/demonstrate insertion and removal
- ☐ Operation of device(s)
- ☐ Care and Maintenance
- ☐ Suggestions for getting used to the device(s)
- ☐ Reasonable expectations
- ☐ Initial sound of voice/wind
- ☐ Battery information/toxicity
- ☐ Teaching materials provided
  - ☐ Importance of speechreading/visual cues
- ☐ Literature/warranty
- ☐ Telephone use
- ☐ Family/Caretaker participation (☐ NA)

POST FITTING FOLLOW-UP DATE(S) _____

Information Discussed with Patient:

- ☐ Adjustments to hearing aid(s)
- ☐ Service/warranty procedures
- ☐ Supplemental/extended warranty coverage
- ☐ Addressed miscellaneous questions/concerns

Aided Testing Completed: ☐ Functional Gain ☐ Real Ear

Overall Prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Could not assess

Audiologist's Recommendations:

1. Audiometric/Hearing Aid Follow-up: ☐ Semi-Annually ☐ Annually ☐ Other _____
2. Consistent hearing aid use is recommended.
3. Patient should contact this facility if he/she has problems with the aid(s) or notices a shift in hearing.
4. Other:

_____

_____

_____

Audiologist Signature: _____ Date: _____ Time: _____

cc: white: ☐ Medical records copies: ☐ _____ ☐ _____ ☐ _____

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PATIENT LABEL

MR.HACF