Patient sticker here

Providence HEALTH CARE
How you want to be treated.

BC Adult Cochlear Implant Program
Hearing Aid Check Form

To be completed by a hearing aid Audiologist/Dispenser

Phone: 604-806-9616 Fax: 604-806-8435

Your patient has been referred for a cochlear implant candidacy assessment at St. Paul's Hospital. In order to accurately determine their candidacy, we must assess their speech understanding ability in the best-aided condition. Their hearing aids/earmolds 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. **We appreciate your cooperation. Your time and effort will allow us to provide the best care for our patients.**

Patient: _____ **Date:** _____

Address: _____ **Phone:** _____

_____ **Email:**_____

Right Hearing Aid		**Left Hearing Aid**	
Manufacturer:	_____	Manufacturer:	_____
Model:	_____	Model:	_____
Serial #:	_____	Serial #:	_____
Fitting Date:	_____	Fitting Date:	_____

Please complete the following and attach a copy of the current audiogram and real-ear tracings (preferably incorporating Real Ear to Coupler Difference) to the form.

- ☐ Current audiogram including word recognition scores (within 6 months)
- ☐ Cleaned and checked hearing aids
- ☐ Confirm appropriate fit of hearing aids/earmolds
- ☐ Current real ear measurements for each hearing aid at user settings
- ☐ A program in each hearing aid to meet prescriptive targets ***if*** real ear targets are not met at user settings *This is important for candidacy assessment. Please indicate which program in hearing aid is set to prescriptive targets. Program #___.

If real ear targets are not met, 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: _____

_____

Recommendation: _____

RAUD/RHIP: _____ Clinic: _____

Audiologist/Dispenser (please print) Clinic Phone: _____

Signature: _____ Clinic Fax: _____