☐ 6. EXPLANATION OF TEST RESULTS *(be concise, emphasize severity and that we can help)*

Before explaining results present Impact Video and leave the room to review results alone.

To begin explanation of results:

Mr./Mrs. ____________________, let me first give you a frame of reference. This is normal, this is functionally deaf, this is you.

Refer back to Brain Sheet and/or Johns Hopkins brain image.

Closing explanation of results:

Mr./Mrs. ____________________, we have covered a lot of information. **I want to ask, how are you feeling right now?**

☐ 7A. COUNSELING PROTOCOL

For the patient: Who encouraged you to come see a hearing professional today?
What has your (husband/wife) been saying to you about the level of communication between the two of you?

For the spouse: What sort of things have you noticed about the level of communication between the two of you?
How long has effective communication been an issue between the two of you?
Do these difficulties in communication with your (husband/wife) concern you?

For the patient: How long have you been aware of this communication issue between the two of you?
Does your (husband's/wife's) concern about your communication as a couple concern you?
Given your concern, would it be fair to say that you are not only here for your (husband/wife), but you are also here for yourself?

For the spouse: You said that you have been aware of this communication difficulty with your (husband/wife) for (#) years. Do I have that right?

For the patient: You said that you have been aware of these communication difficulties for only (#) years. Do I have that right?
However, you did not come in (#) years ago, or (#) months ago, or even (#) weeks ago. What is different now?

☐ 7B. COMMUNICATION ASSESSMENT

Mr./Mrs. ____________________, if you could wave a magic wand and hear normally again in just one environment, what would that environment be? (Insert response below, find cost in quality of life)

Rate	Difficult Listening Environments *(Out of Communication)*	Cost in Quality of Life *(Consequence, Effect, Impact)*

If I can help you communicate more effectively in these environments, is that the result you're looking for? ☐ Yes ☐ No

☐ 8. DEMO

☐ Familiar Voice VOSU ☐ Recorded Speech VOSU ☐ Step-Away Sentences ☐ Music

For the patient: **How would hearing this well all the time improve your life?**

For the spouse: **How would it change your life if Mr./Mrs. ____________ could communicate this well all the time?**

☐ 9. SELECTION / RECOMMENDATION

Custom Impressions and Review

Mr./Mrs. ____________________, your ear canal is (description of ear canal). This makes you a perfect candidate for a (custom power RIC, custom RIC, CIC, IIC). **Let's talk about the engine that goes inside of this model.**

Selection and Recommendation

Style: ☐ RIC ☐ CIC ☐ Other Wireless: ☐ Yes ☐ No Advanced Mics: ☐ Yes ☐ No

Option 1. If it doesn't take food off your table, the best option is... ____________

Option 2. Our next option is the ____________... Its our most popular model... Patients find it provides the best overall value...

Option 3. If you need to be more budget conscious, we offer the ____________.

Which of these do you prefer? (Remain silent: friendly questioning smile with excellent eye contact)

☐ 10. PURCHASE AGREEMENT OR TNT FORM

Select the appropriate: ☐ Complete and Review Purchase Agreement ☐ Complete and Submit TNT Form

HEARING HEALTH REPORT - NEW PATIENT

CLIENT HISTORY

PLEASE PRINT

Last Name ____________________ First Name ____________________ MI _____ ☐ Male ☐ Female

Address ____________________ City ____________________ State ______ Zip __________

Cell Phone ( ) ______ - ________ Home Phone ( ) ______ - ________ Work Phone ( ) ______ - ____

Date of Birth ______ - ______ - ______ ☐ Married ☐ Single ☐ Widow(er) E-mail address ____________________

Occupation ____________________ If retired, what kind of work did you do? ____________________

Who is with you today? ____________________ Relationship ____________________

Primary Care Physician Name ____________________ City ____________ Phone ____________

Insurance Carrier ____________________ I.D. No./Policy No. ____________________

How did you hear about us? ____________________ If you were referred to us, who may we thank? ____________________

I have received a copy of the company's Privacy Practices and understand its contents. ☐ Yes ☐ No

Permission to release test information to physician? ☐ Yes ☐ No

Permission to release test information to designated person(s) listed below? ☐ Yes ☐ No

Name(s) and relationship(s) ____

Patient's Signature ____ Date ____________________

MEDICAL HISTORY

Do you have any allergies? ☐ Yes ☐ No If yes, please list ____________________

Do you have high or low blood pressure? ☐ Yes ☐ No If yes, high or low? ____________________

Are you diabetic? ☐ Yes ☐ No If yes, are you insulin-dependent? ☐ Yes ☐ No

Do you have any arthritis? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, please describe ____________________

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list ____________________

Are you taking any blood thinners? ☐ Yes ☐ No If yes, please list ____________________

Have you been examined by a doctor in the past 6 months? ☐ Yes ☐ No

Have you received any medical or surgical treatment for your hearing loss? .... ☐ Yes ☐ No

PATIENTS: PLEASE DO NOT FILL OUT ANYTHING BELOW THIS LINE.

☐ 1. HEARING HEALTH HISTORY

Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No Type: ____________________

Ear fitted: ☐ Both ☐ Left ☐ Right Vent size: ____________________ Previous Occlusion: ☐ Significant ☐ Slight ☐ None

If yes, and you could improve something about your current hearing aids, what would it be? ____________________

Do you know anyone who wears hearing aids? ☐ Yes ☐ No If yes, who? ____________________

General History

Do you have a family history of hearing loss? .... ☐ Yes ☐ No

Do you have a history of noise exposure? .... ☐ Yes ☐ No

Have you experienced any acute or chronic dizziness/vertigo/imbalance/light-headedness? .... ☐ Yes ☐ No

When was your last hearing test? ________ What was the result or recommendation from that exam? ____________________

In which ear is your hearing most impaired? .... ☐ Left ☐ Right ☐ Same

When did you first notice a decline in your hearing? Within the past... ☐ 90 days ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ 10+ years

Do you know the cause of your hearing loss? (explain) .... ☐ Yes ☐ No

Have you noticed any change in your ability to remember? .... ☐ Yes ☐ No

Do you have ringing in your ears? .... ☐ Yes ☐ No

Do you sometimes hear conversation loud enough but cannot understand the words? (explain) .... ☐ Yes ☐ No

Do you find it difficult to understand conversation in noise? (explain) .... ☐ Yes ☐ No

Do you have trouble hearing on the telephone? ☐ Yes ☐ No ☐ Landline ☐ Cellphone (what kind?) ____________________

Continued on next page

General History, continued

Do you have difficulty hearing your spouse? Others? Women? Children? ☐ Yes ☐ No   Do you live ☐ alone or ☐ with others?

Do others mention you play the radio or TV too loudly? .... ☐ Yes ☐ No

What other comments have others made about your hearing? ____________________

What brings you into our clinic today? ____________________

In what situation do you have the most difficulty understanding, or in what situation would you like to hear better? ____________

If hearing loss is discovered, and we find that hearing aids will help you, are you ready for help today? ...... ☐ Yes ☐ No

☐ 2. PRICING DISCUSSION *(Dialogue)*

Our patients tend to have 3 questions:

1. Do I have a hearing loss? Well, we are going to find that out today.
2. Will hearing aids help? We are going to find that out as well.
3. What do hearing aids cost? *(Refer patient to early pricing push card dialogue.)*

So, Mr./Mrs. ____________________, what we will be doing today is a complete audiometric evaluation to see if you have hearing loss and if so at what level. Then we will do a hearing aid test to see if you are a good candidate for hearing aids. Finally, we will discuss any lifestyle and budget concerns and I will present you with a few options that fit all your needs. **Does that sound reasonable to you?**

☐ 3. VIDEO OTOSCOPY / CERUMEN MANAGEMENT / TYMPANOMETRY

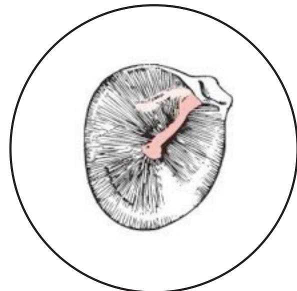
FDA questions

1. Visible congenital or traumatic deformity of the ear? .... ☐ Yes ☐ No
2. Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? .... ☐ Yes ☐ No
3. Any history of, or active drainage from, the ear within the previous 90 days? .... ☐ Yes ☐ No
4. Any history of sudden or rapidly progressive hearing loss within the previous 90 days? .... ☐ Yes ☐ No
5. Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? .... ☐ Yes ☐ No
6. Have you experienced any pain or discomfort? .... ☐ Yes ☐ No
7. Audiometric air-bone gap equal to, or greater than 15dB at 500 Hz, 1000 Hz and 2000 Hz? .... ☐ Yes ☐ No

"How We Hear" push card presentation

Video Otoscopy / Cerumen Management

RIGHT EAR



CLARITY: ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

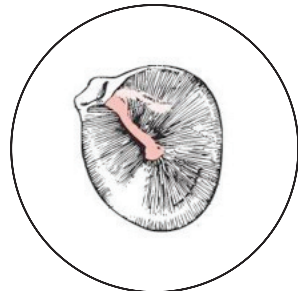
DISCHARGE: ☐ Yes ☐ No

ODOR: ☐ Yes ☐ No

CERUMEN: ☐ Light ☐ Moderate ☐ Heavy

CERUMEN MANAGEMENT: ☐ Yes ☐ No

LEFT EAR



CLARITY: ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

DISCHARGE: ☐ Yes ☐ No

ODOR: ☐ Yes ☐ No

CERUMEN: ☐ Light ☐ Moderate ☐ Heavy

CERUMEN MANAGEMENT: ☐ Yes ☐ No

Tympanometry

RESULT: ☐ Type A (S / D) ☐ Type B ☐ Type C

Acoustic Reflexes

LE: IPSI 500 _____ 1000 _____ 2000 _____ 4000 _____   CONTRA 500 _____ 1000 _____ 2000 _____ 4000 _____

RE: IPSI 500 _____ 1000 _____ 2000 _____ 4000 _____   CONTRA 500 _____ 1000 _____ 2000 _____ 4000 _____

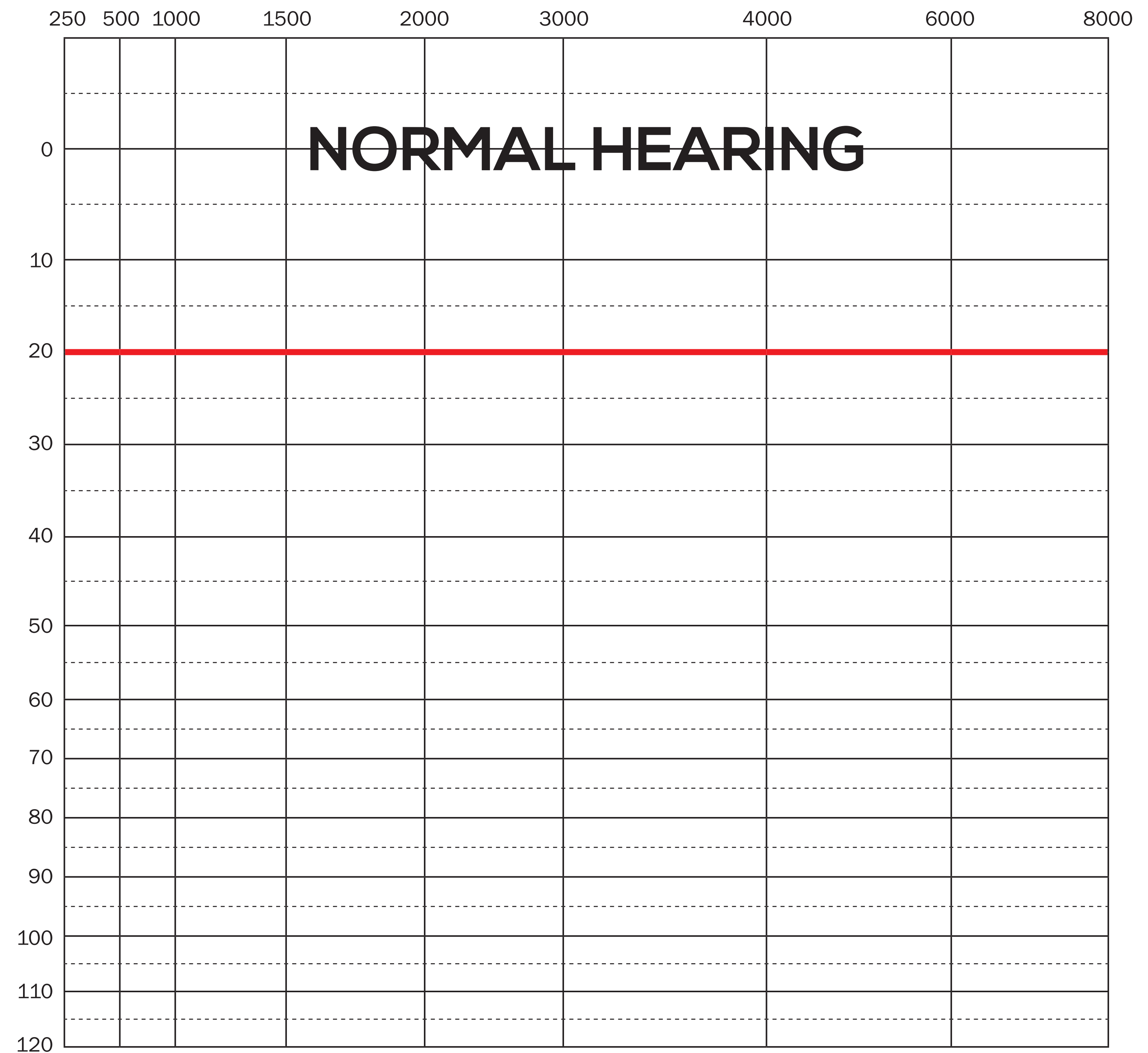
OtoAcoustic Emissions

RESULT: ____________________

☐ 4. FAMILIAR VOICE TEST *(See Insert)*

Perform test with patient's back to the companion. Have companion read at least 25 words at normal conversational level. Both companion and specialist keep track of the patients answers.

☐ 5. COMPLETE EXAM



RIGHT EAR
SRT: _____ MCL: _____ UCL: _____
Discrim %: _______ AI %: _______

BINAURAL
Discrim %: __________
PB50 %: __________
QuickSIN: __________

LEFT EAR
SRT: _____ MCL: _____ UCL: _____
Discrim %: _______ AI %: _______

CASE HISTORY:

Previous Instrument: _______ with vent size _____

Previous Occlusion: ____________________

Special Consideration: ____________________

HEARING PROFESSIONAL:

Name: ____________________

Title: ____________________

License Number: ____________________