REPORT OF HEARING AND EAR ASSESSMENT

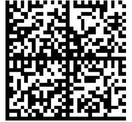
State Form 35055 (R7 / 3-19) / VRS 2051
FAMILY AND SOCIAL SERVICES ADMINISTRATION
VOCATIONAL REHABILITATION

TO EXAMINER(S): Please send completed form to:

Counselor Name:

Address: Vocational Rehabilitation
PO Box 280
Indianapolis, IN 46206

Telephone:
Fax:
E-mail: @fssa.in.gov



PART I *(To be completed by counselor or applicant.)*

The information recorded on this form by the VR counselor is to provide the examiner with pertinent background to assist in evaluating the extent of hearing impairment of this referral. It is not to be used for any other purpose.

GENERAL INFORMATION

Name of applicant (*last, first, middle initial)*	Date of birth *(month, day, year)*	Current occupation

Home address (*number and street, city, state, and ZIP code)*

Home telephone number *(including area code)*	Mobile telephone number *(including area code)*	Business telephone number *(including area code)*
( )	( )	( )

Purpose of examination

CASE HISTORY

Is the applicant experiencing any of the following conditions? (*Medical or other evidence attached – check those that apply.)*

- ☐ Visible congenital or traumatic deformity of the ear
- ☐ History of active drainage from the ear within the previous ninety (90) days
- ☐ History of sudden or rapidly progressive hearing loss within the last ninety (90) days.
- ☐ Acute or chronic dizziness
- ☐ Unilateral hearing loss of sudden or recent onset within the previous ninety (90) days
- ☐ Continuous head noise or ringing in the ears (*tinnitus).*
- ☐ Cerumen accumulation (ear wax) or foreign body in the ear canal.

Is there any remarkable ear pathology? *(Specify treatment and / or surgery; give types and dates.)*

Is the applicant taking any medication? ☐ Yes ☐ No

If yes, specify the medication and the reason for which it is being used.

What is the cause of hearing loss and when did it take place? *(This information is to be provided if the applicant is able to answer this question.)*

Is the applicant using a hearing aid? ☐ Yes ☐ No

If yes, specify in what situations the hearing aid is being used.

Is the applicant having difficulty utilizing a hearing aid? ☐ Yes ☐ No

If yes, specify what reason(s).

Is there a family history of hearing impairment or deafness? ☐ Yes ☐ No

If yes, what relation(s)?

What is the applicant's preferred mode of communication?

- ☐ Discriminating Speech Through a Hearing Aid
- ☐ Sign Language
- ☐ Speechreading
- ☐ Oral
- ☐ Paper and Pencil
- ☐ Braille
- ☐ Tactile Sign

Name	Date *(month, day, year)*

PART II ***(To be completed by physician.)***

DIAGNOSIS

1. Type of hearing impairment

☐ Sensori-neural ☐ Conductive ☐ Mixed ☐ Central

2. Pathology of hearing loss

3. Characteristics of hearing impairment: *(Check those that apply.)*

☐ Stable ☐ Fluctuant ☐ Improving

☐ Slowly Progressive – Why?

☐ Rapidly Progressive – Why?

PROGNOSIS AND RECOMMENDATIONS

1. Prognosis as to receptivity of hearing impairment to treatment:

2. Treatment recommended – medical, surgery, or other therapy:

3. New hearing aid(s) recommended?

☐ Yes ☐ No ☐ Right Ear ☐ Left Ear

If yes, describe characteristics of amplification.

4. Does this individual have any hearing-related conditions (such as *Meniere's Disease, Tinnitus, Recruitment, etc.)*

☐ Yes ☐ No

If so, please specify condition and related restriction.

5. If so, does this condition restrict the work activity performed by this individual?

☐ Yes ☐ No

If so, please explain how the work activity is restricted.

Signature of Physician	Date (*month, day, year)*

Place	Title

(Client ID)

Name	Date *(month, day, year)*

PART III *(To be completed by examiner.)*

AUDIOMETRIC EXAMINATION

Instrument used

Please enter the appropriate symbol for the **right ear in red**; the **left ear in blue.**

Please indicate: ☐ Aided Score and ☐ Unaided Score

HEARING LEVEL DECIBELS	125	250	500	1000	2000	4000	8000	
0								0
10								10
20								20
30								30
40								40
50								50
60								60
70								70
80								80
90								90
100								100

110 **FREQUENCY IN HERTZ (Hz)** 110

AUDIOGRAM KEY

	Right	Left
AC Unmasked		
AC Masked		
BC Mastoid Unmasked		
BC Mastoid Masked		
BC Forehead Masked		

BOTH

BC Forehead Unmasked	
Sound Field	$

EXAMPLES OF NO RESPONSE SYMBOLS

PURE TONE AVERAGES		SPEECH AUDIOMETRY
EAR	Four Frequencies 500, 1000, 2000 and 4000 Hz	Speech Reception Threshold (SRT)
RIGHT	dB	dB
LEFT	dB	dB

SPEECH AUDIOMETRY				
Discrimination score to be obtained at 50 dB Hearing Level.		Discrimination score to be obtained at Maximum Comfort Level (MCL) in Quiet.		
EAR	Speech Discrimination Scores	EAR	Speech Discrimination Scores *(To be administered in Quiet only.)*	
RIGHT	Quiet **% at 50 dB HL**	RIGHT	MCL dB	%
LEFT	Quiet **% at 50 dB HL**	LEFT	MCL dB	%
SOUND FIELD	**Noise at 0 dB S/N - *required*** **% at 50 dB HL**			

Name	Date *(month, day, year)*

Special tests:
Additional comments:

Report of Hearing and Ear Assessment

Hearing Aid Evaluation

Make and Model of left hearing aid	Date left hearing aid was dispensed *(month, day, year)*
Is the left hearing aid currently functioning as programmed? ☐ Yes ☐ No	If no, can the left hearing aid be repaired (regardless of age of aid or cost)? ☐ Yes ☐ No
How many times has the left hearing aid been sent in for repairs?	
If the left hearing aid is not meeting consumer's needs, please explain why:	
Make and Model of right hearing aid	Date right hearing aid was dispensed *(month, day, year)*
Is the right hearing aid currently functioning as programmed? ☐ Yes ☐ No	If no, can the right hearing aid be repaired (regardless of age of aid or cost)? ☐ Yes ☐ No
How many times has the right hearing aid been sent in for repairs?	
If the right hearing aid is not meeting consumer's needs, please explain why:	

Signature of audiologist	Date of evaluation *(month, day, year)*
Printed name	License number