Ear Care Pathway

New patient form

AUDIBEL

Patient Name: _____ Today's Date: _____

Street: _____ City: _____ State: _____ Zip Code:_____

Email Address: _____ Cell Phone: _____

Occupation: _____ Date of Birth: _____
(if retired, please list occupation while working)

Primary Physician (First & Last Name): _____ Physician Phone Number: _____

How did you learn about us: ☐ Referral ☐ Friend ☐ Newspaper ☐ Google ☐ Social Media ☐ Other:_____

Hearing Checklist

YES	NO	*Please answer how well you hear.
☐	☐	You can hear, but have difficulty understanding.
☐	☐	You have difficulty understanding children or those with high-pitched voices.
☐	☐	You find yourself complaining that some people mumble or slur their words.
☐	☐	You have difficulty understanding what's being said unless you are facing the person speaking.
☐	☐	You are continually asking certain people to repeat themselves, even though they feel they are speaking loud enough.
☐	☐	You prefer the TV or radio louder than others do.
☐	☐	You have difficulty understanding conversation within a group of people.
☐	☐	You avoid group meetings, social occasions, public facilities, or family gatherings where listening may be difficult.
☐	☐	You have trouble hearing at places of worship or other public gatherings—especially where sound sources are at a distance.
☐	☐	You experience ringing, hissing, buzzing, whistling, roaring, or even chirping noises in your ears.

INDEX OF SOCIAL IMPAIRMENT

Total YES Answers: _____ X 10 = _____ % Social Impairment Index

How can I serve you today? _____

Needs Assessment

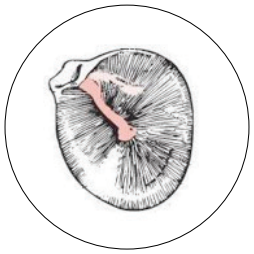
Rate	Environmental Struggles Tell me about an environment where you are struggling to hear?	Quality of Life Impact/Emotion Help me understand. / Tell me more.

Is the summary correct? ☐ Yes ☐ No

Just so we are on the same page, what are we hoping to accomplish today? _____

Otoscopy & FDA Questions

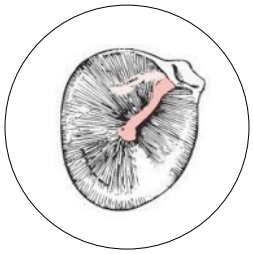
LEFT EAR



Cerumen: ☐ Light ☐ Moderate ☐ Heavy

Cerumen Management: ☐ Yes ☐ No

RIGHT EAR



Cerumen: ☐ Light ☐ Moderate ☐ Heavy

Cerumen Management: ☐ Yes ☐ No

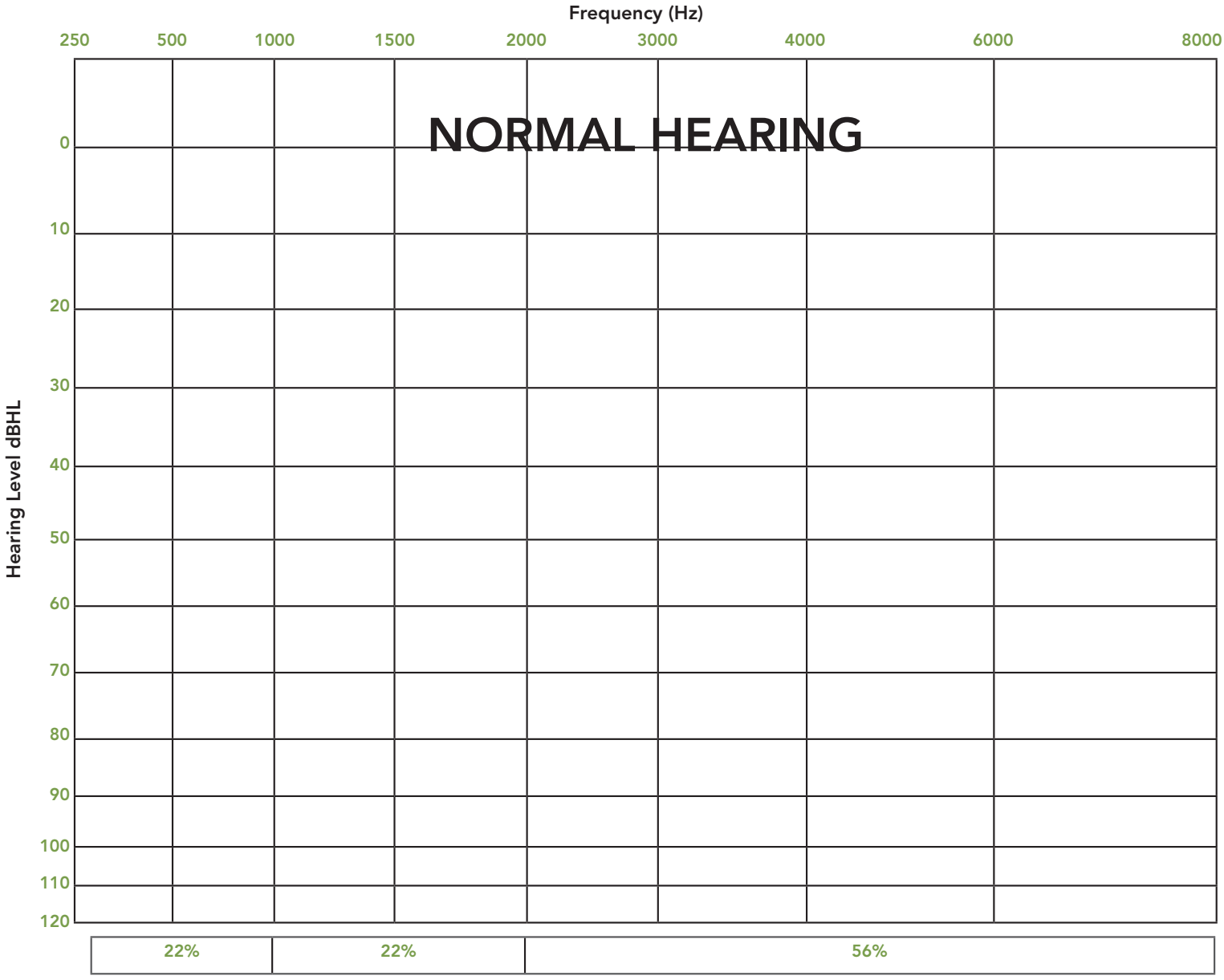
1. Visible congenital or traumatic deformity of the ear? ..... ☐ Yes ☐ No
2. Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ..... ☐ Yes ☐ No
3. Any history of, or active drainage from, the ear within the previous 90 days? ..... ☐ Yes ☐ No
4. Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ..... ☐ Yes ☐ No
5. Have you experienced any acute or chronic dizziness? ..... ☐ Yes ☐ No
6. Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ..... ☐ Yes ☐ No
7. Have you experienced any pain or discomfort? ..... ☐ Yes ☐ No
8. Any ringing or other noises in the ears? ..... ☐ Yes ☐ No

Notes:

Hearing Examination

Patient Name: _____ Today's Date: _____/ _____/ _____

Examiner:_____ Title: _____ License #: _____



SYMBOLS	LEFT	RIGHT
Unmasked AC	X	○
Unmasked BC	>	<
Masked AC	□	△
Masked BC	]	[
No Response	↘	↙

	SRT	UCL	MCL	WORD DISCRIMINATION	
RIGHT	dB	dB	dB	dB	%
LEFT	dB	dB	dB	dB	%
BINAURAL	dB	dB	dB	dB	%

- ☐ Insert Phones
- ☐ Headphones
- ☐ Sound Field

Unaided Speech/Current Hearing Device Assessment

Check the CORRECT words. For incorrect words, write exactly what patient said on the line.

☐ Sick	_____	☐ Voice	_____
☐ Tax	_____	☐ Spit	_____
☐ See	_____	☐ Chair	_____
☐ Ticks	_____	☐ Leaf	_____
☐ Shout	_____	☐ Chicks	_____
☐ Lease	_____	☐ Cheap	_____
☐ Thick	_____	☐ Hits	_____
☐ Week	_____	☐ Fixed	_____
☐ Leap	_____	☐ Licked	_____
☐ Fist	_____	☐ Kicks	_____
☐ Care	_____	☐ Cheese	_____
☐ Sipped	_____	☐ Share	_____
☐ Sheep	_____		

Total CORRECT Answers: _____ X 4 = _____ % of Current Ability

New Device Aided Assessment

Have the companion stand 5 feet behind the patient and have them ask 3 questions. Have the companion move back a few steps with each question - "What did you have for breakfast today? What are you having or what did you have for lunch? What will you have for dinner tonight?"

Professional Recommendation: