Indiana University Health

AUDIOLOGY-COCHLEAR IMPLANT PROGRAM

THIS FORM IS TO BE FILLED OUT BY THE PATIENT'S AUDIOLOGIST

Dear Colleague;

Your patient, _____ is planning to visit the Indiana University Cochlear implant program in the near future. We are anxious to ensure that we plan appropriately for their visit, and hope that you can provide us with some information about the patient's hearing and hearing aid fitting.

Please send us a copy of the patient's most recent audiogram. If the loss a progressive or fluctuates, a "snapshot" of that history.

Right ear hearing aid: Brand and Model_____

Type: BTE ITE ITC Date fit:_____ Consistent use? _____

If the aid has data logging, what is the average daily use: _____

Left ear hearing aid: Brand and Model_____

Type: BTE ITE ITC Date fit:_____ Consistent use? _____

If the aid has data logging, what is the average daily use: _____

When did the patient last see you? _____

What targets were used in the fitting and verification of your patient's hearing aids? _____

We recognize that even when targets are used to set hearing aids initially, they are sometimes modified based on patient reports. If such changes have been made, please briefly describe those reports and the adjustments?

Is the patient using a hearing aid with sound recovery or frequency compression?

Do you know if the patient's ear molds are currently fitting well? Yes No

Your name and phone number: _____

According to departmental policy, we cannot modify your patient's hearing aid fitting. As such, if you believe the patient is in need of an appointment with you to ensure the best possible fit, we would appreciate your consultation with the patient.

Thank you for your lending your expertise in the care of your patient.

Please return forms by mail, fax or as an email attachment to:

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