



**SECTION A - GENERAL INFORMATION**

Claim # \_\_\_\_\_

1	Worker's last name	First name	Initial	Audiologist's last name	First name
2	Mailing address Province	Contact telephone	Mailing address Province	WorkplaceNL billing number	
	Postal code	Date of birth yyyy/mm/dd	Postal code	Audiologist ID:	
3	MCP	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Telephone	Reporting fee requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Occupation	Employer	Fax	Date of visit yyyy/mm/dd	

**SECTION B - EQUIPMENT INFORMATION**

5	Was the equipment biologically calibrated on the day of the worker's hearing assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your equipment been electroacoustically calibrated within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**SECTION C - MEDICAL INFORMATION**

6	Onset of hearing loss: yyyy/mm/dd	Type of hearing loss: <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left	Is this the initial visit? <input type="checkbox"/> Yes <input type="checkbox"/> No
7	Other relevant history reported:		Details
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tinnitus <input type="radio"/> Right <input type="radio"/> Left	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent Number of years:
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Otalgia <input type="radio"/> Right <input type="radio"/> Left	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Otorrhea <input type="radio"/> Right <input type="radio"/> Left	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness / imbalance	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facial numbness	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head injury	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Familial hearing loss	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic disease	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medications	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other		

**SECTION D - AUDIOLOGIC ASSESSMENT**

8	Audiometry crosschecks:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	SRT vs. PTA (.5k, 1k, 2k, OR .5k, 1k AVG.) ± 7-10 dB
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tympanometry agrees with nature of hearing loss
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acoustic reflexes as anticipated for nature and degree of hearing loss
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inter-octaves assessed as needed (include 3,000 Hz; others only if >20 dB difference in adjacent octaves)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reliability statement made
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker was reportedly free of hazardous noise exposure for 16 hours immediately prior to assessment
If no to any of the above, provide details: _____		
9	Special audiologic test strategies applied:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ascending threshold assessment
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intensity step size from ≤ 5 dB
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulse or warble tones
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other diagnostic tests (ABR, OAE, etc.)
If yes to any of the above, provide details: _____		
Test behaviours:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Discrepancy between history, thresholds and/or behaviours outside test booth	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Atypical response patterns	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Test inconsistency	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual speech audiometric patterns or responses	
If yes to any of the above, provide details: _____		
<b>Please attach worker's audiogram</b> A reporting fee will only be paid if an audiogram is attached.		

**SECTION E - CAUSE AND EFFECT ANALYSIS** *excluding traumatic hearing loss*

10	Is there SNHL? <input type="checkbox"/> Yes <input type="checkbox"/> No	For broadband noise exposure, is the predominate hearing loss in the 3000-6000 Hz region or if tonal noise exposure, is predominate hearing loss within 1 to 1½ octaves above the noise primary frequency? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Noise exposure condition unknown
	Are any of the thresholds ≥ 75 dB HL? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
11	Does comparison with older audiograms show onset and progression of hearing loss predominately in the first 10 years of noise exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available	Does comparison with older audiograms show increasing hearing loss with increasing intensities of noise exposure levels? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available
	Comments: _____	Comments: _____
12	What does the worker report? <input type="checkbox"/> Stable hearing loss <input type="checkbox"/> Slowly progressing hearing loss	Does the worker report communication difficulties consistent with the hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION F - ADDITIONAL COMMENTS**

13	Comments: _____
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**SECTION G - SIGNATURE**

14	I certify that this is a complete and accurate report and I have received no prior payment from WorkplaceNL related to this visit. I certify that I am the audiologist who has completed both the assessment and this form.	Date yyyy/mm/dd _____
Signature _____		