HEARING EXAMINATION

Date: _____ Doctor: _____

Participant's Name: _____ DOB: _____

Staff escorting to appointment: _____

Allergies: See Attached

Current Medications, Dx's and Diet: See Attached

Reason for Appointment/ Comments:

TO BE COMPLETED BY ATTENDING PHYSICIAN

Presently Wearing Hearing Aids? ☐ Yes ☐ No

Date of Last Exam: _____ Provider: _____

Exam Findings: _____

_____

_____

Recommendations: _____

_____

_____

_____ _____

Physician Signature Date

_____ _____

Next Appointment Referral if Necessary

HEARING CONSENT

Based on the above, I

Check One

☐ Do Agree

☐ Do Not Agree

I was informed of the hearing exam and treatment involved, I

Check One

☐ Do Agree

☐ Do Not Agree

Participant Signature	Date
Guardian Verbal (If Applicable)	Date
Guardian Written (If Applicable)	Date

MEDICAL APPOINTMENT NARRATIVE

Participant (print): _____ Date: _____

_____

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_____ _____

Signature Title