

Complete this form to let us know when a patient has made their final hearing aid selection at the end of the trial period (30 to 90 days) during the initial bundle. The patient must complete sections E and G of this form after they select their final hearing aid.

A hearing health care provider must complete this form with their patient. The patient must sign in person.

Log in at wsib.ca/submit to submit the completed form.

For more information on our hearing services program, visit wsib.ca/hearingservicesprogram.



Hearing services initial bundle – Outcome report

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

Initial services - date of initial assessment:

Patient is retired Patient is employed B. Health care provider information Audiologist Hearing instrument specialist Registration/license number (College of Audiologists and Speech Language Pathologists of Ontario/Association of Hearing Instrument Practitioners of Ontario) Health care provider name Clinic address (number, street, apartment) City or town Province Postal code Postal code Postal code Telephone WSIB provider ID C. Barriers to using hearing ald(s) (please check all that apply) None Health Social Cognitive Other Date of self-discharge (dd/mmm/yyyy) D. Hearing services provided (to be completed by the health care provider, please check all that apply) 1. Patient assessment and evaluation: Audiometric testing (if not conducted in the past six months) Cerumen management Evaluation of communication needs Pre-fitting counselling and information for patients Selection of appropriate Pre-fitting counselling and information for patients Selection of appropriate Patient is employed Insertion is employed Insertion and Speech Language Pathologists of Ontario/Association of Flearing Special	A. Patient information								
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neuring and teermology									
Douting maintenance, acfe storage warrenty information	hearing aid technology								
Prescription *keep a copy on file Patient education (e.g., counselling, education, information and social supports)	•	Routine maintenance, safe storage, warranty information Patient education (e.g., counselling, education, information and social supports)							
Other, please specify: Verification using real ear measurements *keep a copy on file	Other, please specify:	Verification usin	Verification using real ear measurements *keep a copy on file						
Other, please specify:		Other, please specify:							



D. Hearing servi	es provided (to be	e completed by the h	ealth care	provider, please	e check all the	at apply	y) (continued)	
3. Trial period fo	low-up							
Re-coachi	g			Adjustment of	f physical fit	and mi	nor reprograr	nming
Ear and/or	device cleaning			Other, please	specify:			
Validation:	Complete section	n G: Validation and h	earing ai	d outcome ques	tionnaire for	final he	earing aid sel	ected.
Total number of	visits (from dispe	nse to end of trial pe	riod)	1-2 visits	3-4 visits	5	or more visi	ts
E. Final hearing	evice selection							
Manufacturer			Mode	I	Туре		Serial numb	per(s)
Date of dispens	of final hearing a	aid selected (dd/mm	m/yyyy)		Right		Left	Both ears
		pleted by the patient						
		aid(s) (check all that		_				
At home	At work	For social/leisur		Other				
	•	ng aids to my (check			hono	iDhor	20	
	Corded home phone Cordless home phone Android smartphone iPhone							
Other 3. I require information on how the hearing aid(s) will operate with my hearing							N/A	
protection devices.							IN/A	
4. I will have	support with my	hearing aid(s) needs	from my	(check all that a	apply):			
Family Friends Power of attorney (POA) Personal support worker							worker	
Care/as	istance living fac	cility	Othe	r				
G. Validation and	hearing aid outco	ome questionnaire - n	ninimum	30 to maximum 9	90 days post-	fitting		
Completed by p	tient? Yes	s, see details below	No	o, please provide	e explanation	l		
Patient to com to 90 days pos		g aid outcome ques	stionnair	e once they ha	ve selected	their f	inal hearing	aid, within 30
		e your ability to use t ee), 3 (undecided), 2			isagree) or n	/a		Score
1. I can inse	the batteries int	o my hearing aids.						
2. I can tell t	e right hearing a	id from the left heari	ng aid.					
3. I can inse	t the hearing aids	s into my ears.						
4. I can oper	ate all of the cont	rols on my hearing a	ids (butto	ons, switches).				
5. I can oper	ate the remote co	ontrol or other access	sories for	my hearing aids	S.			
6. I can clea	and care for my	hearing aids.						
7. I am gettir	g used to the sou	und quality of my hea	aring aids	S.				
8. I am gettir	g used to the fee	ling of the hearing a	ids in my	ears.				
		und of my own voice			aids.			
_	<u>-</u>	ation in a quiet place						
		ation in a noisy place						

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G. Validation and hearing aid outcome questionnaire - minimum 30 to maximum 90 days post-fitting (continued)						
12. I can hear the television when I am wearing my hearing aids.						
13. I can understand conversation on the telephone when I wear my hearing aids.						
14. Overall, I am satisfied with my hearing aids.						
15. Is there another situation you would like to describe related to the use of your hearing aids? (Describe)						
H. Hearing health care provider signature						
Name	Signature	Date (dd/mmm/yyyy)				
I. Patient declaration and signature						
I received all the services as described above and I am satisfied.						
Name	Signature	Date (dd/mmm/yyyy)				

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