WSIB Ontario | wsib.ca

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/en/hearing-services-directory.

Billing information:

- Submit your bill online for the initial bundle of services. The service date is the date your patient **started** their hearing aid trial. The initial bundle will be paid when the trial is complete.
- Submit your bill online for completing this report. The service date is the date that your patient **ended** their hearing aid trial.

WSIB Ontario

Hearing services initial bundle – Outcome report

Claim number

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

☐ Hearing aid trial start date (service date):

A. Patient information			
Last name	First name	Initial	Date of birth (dd/mmm/yyyy)
☐ Patient is retired ☐ Patient is employed	Job title (if 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 name			
Clinic address (number, street, apartment)				
City or town	Province	Postal code	Telephone	WSIB provider ID

C. Barriers to using hearing aid(s) (please check all that apply)	
☐ None ☐ Health ☐ Social ☐ Cognitive ☐ Other	
Please provide details:	
☐ Patient did not return/self-discharged from hearing loss program	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 hearing aid technology
   - ☐ Prescription ***keep a copy on file**
   - ☐ Other, please specify:

2. Dispensing and fitting of hearing aid technology:
   - ☐ Listening check and electroacoustic measures
   - ☐ Hearing aid programming (including wireless pairing)
   - ☐ Physical fit and sound quality of hearing aid
   - ☐ Hearing aid instructions
     - ☐ Insertion and removal of instruments
     - ☐ Batteries (size, how to change, disposal)
     - ☐ Usage patterns/adjustments
     - ☐ Use of remote controls and accessories
     - ☐ Access to multiple programs for varying listening situations
     - ☐ Telephone use
     - ☐ Routine maintenance, safe storage, warranty information
   - ☐ Patient education (e.g., counselling, education, information and social supports)
   - ☐ Verification using real ear measurements ***keep a copy on file**
   - ☐ Other, please specify:

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Claim number

D. Hearing services provided (to be completed by the health care provider, please check all that apply) (continued)

3. Trial period follow-up

- ☐ Re-coaching
- ☐ Adjustment of physical fit and minor reprogramming
- ☐ Ear and/or device cleaning
- ☐ Other, please specify:
- ☐ Validation: Complete section G: Validation and hearing aid outcome questionnaire for final hearing aid selected.

Total number of visits (from dispense to end of trial period) ☐ 1-2 visits ☐ 3-4 visits ☐ 5 or more visits

E. Final hearing device selection

Manufacturer	Model	Type	Serial number(s)

Date of dispense of final hearing aid selected (dd/mmm/yyyy)

☐ Right ☐ Left ☐ Both ears

F. Using the hearing aid (to be completed by the patient)

1. I need to wear my hearing aid(s) (check all that apply):
   ☐ At home ☐ At work ☐ For social/leisure ☐ Other
2. I need to connect my hearing aids to my (check all that apply):
   ☐ 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 protection devices. ☐ Yes ☐ No ☐ N/A
4. I will have support with my hearing aid(s) needs from my (check all that apply):
   ☐ Family ☐ Friends ☐ Power of attorney (POA) ☐ Personal support worker
   ☐ Care/assistance living facility ☐ Other

G. Validation and hearing aid outcome questionnaire - minimum 30 to maximum 90 days post-fitting

Completed by patient? ☐ Yes, see details below ☐ No, please provide explanation

Patient to complete this hearing aid outcome questionnaire once they have selected their final hearing aid, within 30 to 90 days post-fitting.

The following statements describe your ability to use the hearing aids. Range: 5 (strongly agree), 4 (agree), 3 (undecided), 2 (disagree), 1 (strongly disagree) or n/a	**Score**
1. I can insert the batteries into my hearing aids.	
2. I can tell the right hearing aid from the left hearing aid.	
3. I can insert the hearing aids into my ears.	
4. I can operate all of the controls on my hearing aids (buttons, switches).	
5. I can operate the remote control or other accessories for my hearing aids.	
6. I can clean and care for my hearing aids.	
7. I am getting used to the sound quality of my hearing aids.	
8. I am getting used to the feeling of the hearing aids in my ears.	
9. I am getting used to the sound of my own voice when I wear my hearing aids.	
10. I can understand a conversation in a quiet place when I wear my hearing aids.	
11. I can understand a conversation in a noisy place when I wear my hearing aids.	

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)