



Australian Government

Comcare

HEARING AID REQUEST FORM

This form is used to collect information needed to assess an individual's entitlement to hearing aids in accordance with the *Safety, Rehabilitation and Compensation Act 1988*.

This form must be completed and signed by an audiologist, audiometrist or appropriately qualified hearing specialist (e.g. an ear, nose and throat surgeon).

All sections of the form must be completed. Incomplete forms may result in a request for more information. If you are unable to complete a section please provide reasons why.

The information requested is for use by Comcare but may be released to rehabilitation providers, case managers, or other people as required by law.

Your privacy is important to us. For information about how we handle your personal information, please visit www.comcare.gov.au/privacy or contact us on 1300 366 979 and request a copy of our Privacy Policy.

1. EMPLOYEE'S PERSONAL DETAILS

Surname	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Given names	<input type="text"/>	Claim number	<input type="text"/>
Address	<input type="text"/>		
Telephone number	<input type="text"/>	Email	<input type="text"/>

Is the employee eligible to receive hearing aids funded by another scheme?

Office of Hearing Services—Hearing Services Program Department of Veterans Affairs

Commonwealth Rehabilitation Services (CRS)

Other (please provide detail)

Note: If the employee is eligible to receive aids under another scheme they can do so.

2. TREATING AUDIOLOGIST/AUDIOMETRIST/ENT SURGEON DETAILS

Name	<input type="text"/>		
Practice	<input type="text"/>		
Address	<input type="text"/>		
Telephone number	<input type="text"/>	Fax number	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>

3. CLINICAL HISTORY

Nature of hearing loss

Degree: Right
Left

Type: Right Sensorineural Conductive Mixed Tinnitus
Left Sensorineural Conductive Mixed Tinnitus

Cause of hearing loss

Details of any current aid(s)

If you are recommending replacement of current aid(s) please provide rationale

4. HEARING ASSESSMENT

Date of assessment

Please attach a copy of the test results to this form including an audiogram.

Summary of test results

If there is any change from previous results, please advise what the change can be attributed to?

5. COMMUNICATION NEEDS ASSESSMENT

This section requires details of the employee's current communication needs. The information will be used to identify hearing goals and to assist in identifying hearing aids suitable for the employee's needs.

You may attach any similar evidence (such as a *Client oriented scale of improvement*) in lieu of completing this section.

What are the current communication activities and related goals?

These should be specific, achievable and measurable goals linked to actual communication activities.

Activity Examples: > socialising in small groups—communicating in a quiet environment > watching television—hearing the television	Frequency Number of times aid(s) will assist per day, week, month
1.	
2.	
3.	
4.	
5.	
6.	

6. HEARING AID REQUIREMENTS

This section requires details of the type of hearing aid medically required to address the compensable condition. Please tick the appropriate boxes.

Style

- Hearing aid Assistive listening device
 Monaural Binaural

Is there a hearing aid(s) on the Australian Government Office of Hearing Services Free-to-client schedule that you could provide to meet the employee's needs? (this schedule is available at www.hearingservices.gov.au).

- Yes—If yes, please recommend at least one aid on the schedule at Section 7 below.
- No—If no, please explain any functional requirements not available in aids on the schedule and why they are needed to meet the employee's hearing goals listed above.

7. RECOMMENDED HEARING AIDS

Please recommend a suitable aid or aids that could meet the employee's needs at an appropriate cost (including a suitable aid on the Free-to-client schedule where possible).

1. Manufacturer	<input type="text"/>
Model number	<input type="text"/>
Model name (in full)	<input type="text"/>
Price	<input type="text"/>

Rationale

Why was the recommended hearing aid(s) selected? How will it assist in managing the hearing loss on a day to day basis, meeting communication needs and goals?

Warranty details

1 year 2 years 3 years Other (please provide detail)

2. Manufacturer	<input type="text"/>
Model number	<input type="text"/>
Model name (in full)	<input type="text"/>
Price	<input type="text"/>

Rationale

Why was the recommended hearing aid(s) selected? How will it assist in managing the hearing loss on a day to day basis, meeting communication needs and goals?

Warranty details

1 year 2 years 3 years Other (please provide detail)