

**SECTION II TO BE COMPLETED BY AUDIOLOGIST PRIOR TO MEDICAL CLEARANCE**

**Note to Audiologist: By completing this section you agree to fit our instrument at no cost to the patient. For questions on our protocol contact us at Lionshab24B@aol.com**

Is applicant a current hearing aid user? \_\_\_\_\_ Was it provided by Lions? \_\_\_\_\_ When? \_\_\_\_\_  
If yes, what make and model / type of hearing aid? \_\_\_\_\_

**HEARING TEST DATA**

Threshold @ 500 Hz (in dBHL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold @ 1000Hz (in dBHL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold @ 2000Hz (in dBHL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold @ 3000Hz (in dBHL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

Threshold @ 4000Hz (in dBHL's): Left: \_\_\_\_\_ Right: \_\_\_\_\_

What is the unaided discrimination at 45dB? \_\_\_\_\_

What is the unaided discrimination at applicant MCL? \_\_\_\_\_

Which ear to be fit? \_\_\_\_\_ (if only one aid provided) Male: \_\_\_ Female: \_\_\_ Shell color: \_\_\_\_\_

**Categorization of hearing aid need:**

Would you classify the hearing loss as: \_\_\_\_\_ Mild/ \_\_\_\_\_ Moderate / \_\_\_\_\_ Severe/ \_\_\_\_\_ Profound/

Tone control needed on the aid: [ ] Yes [ ] No Power control needed on the aid? [ ] Yes [ ] No

Tester Comments: \_\_\_\_\_

Preferred Manufacturer: \_\_\_\_\_ Don't send: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Organization name: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION III MEDICAL CLEARANCE**

**ONCE YOU HAVE OBTAINED A HEARING TEST, A MEDICAL CLEARANCE MUST BE SIGNED BY AN ENT OR YOUR PRIMARY PHYSICIAN**

**[To be completed by a medical Doctor]**

**The applicant \_\_\_\_\_, has been evaluated and determined not to have any medical contraindications for the use of a hearing aid.**

Physician signature: \_\_\_\_\_ date: \_\_\_\_\_

Print Physician's name: \_\_\_\_\_