Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
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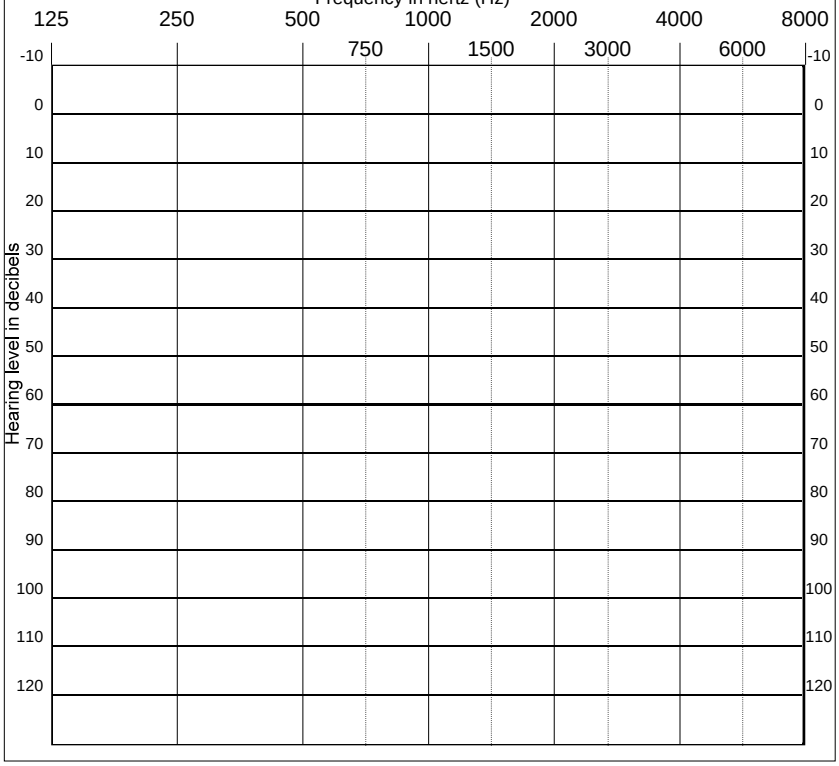
C662
HEARING LOSS SERVICES
HEARING LOSS ASSESSMENT

WORKER DETAILS

Surname	First Name and Initial			WCB Claim Number
				Date of Birth *(Year / Month / Day)*
Address Street	City/Town	Province	Postal Code	Telephone Number
Is the client working? ☐ Yes ☐ No	Booking requested by			Date of Service *(Year / Month / Day)*

Puretone Audiometry



Speech Audiometry

	SRT	SAT	MASK	Word Recognition %	Word Recognition H L	Word Recognition MASK	Word Recognition IN	MCL	UCL
R									
L									
SF									
AID									

Speech Materials | SRT/SDT DISCRIM

MASK | MLV ☐ REC ☐

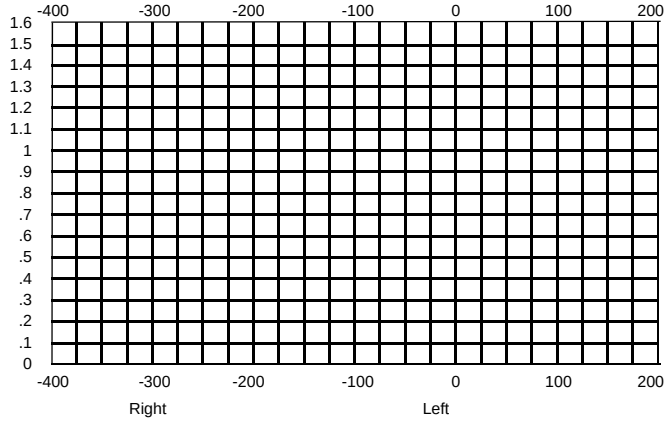
EST. Accuracy: _____

Insert Headphones ☐ Yes ☐ No

Key	Air Unmasked	Air Masked	Bone Unmasked	Bone Masked	No Response
Right	○	△	<	⊏	↙
Left	×	□	>	⊐	↘

Middle Ear Function

Tympanograms
Pressure mm H2 O



Right	Left
Type	Type
ME Pressure	ME Pressure
Compliance	Compliance
Volume	Volume

Acoustic Reflexes

	Right Contra / Tone R Probe L	Right IPSI / Tone R Probe R	Left IPSI / Tone L Probe L	Left Contra / Tone L Probe R
500 Hz				
1000 Hz				
2000 Hz				
4000 Hz				

Reflex Decay:	RIGHT	LEFT
500 Hz	negative/positive	negative/positive
1000Hz	negative/positive	negative/positive

Abbreviations

CNT: Did/Could Not Test
A: Aided
SAT: Speech Recaption/Awareness Threshold
SF: Sound Field
MCL: Most Comfortable Loudness Level
UCL: Uncomfortable loudness Level
MLV: Monitored Live Voice
HL: Hearing Level
NBN: Narrow Band Noise
FM: Frequency Modulation
WNL: Within Normal Limits
CNM: Could Not Mask
NR: No Response
VIB: Vibrotactile

(Surname)	*(First Name)*	Claim Number:

Background Information

	Right (R)	Left (L)
Hearing Difficulty	☐	☐
Tinnitus Intermittent	☐	☐
Tinnitus Constant	☐	☐
Pressure / Fullness	☐	☐
Ear Infections	☐	☐
Surgery	☐	☐
Head Trauma	☐	☐
Ear Pain	☐	☐

Current Hearing Aid ☐ Right ☐ Left

Style _____

Make _____

Model _____

Serial Number _____

Date Purchased _____

☐ Vertigo _____
☐ E.N.T _____
☐ Infectious Diseases _____
☐ Congenital Difficulties _____
☐ Noise Exposure _____
☐ Ototoxic Medications _____
☐ Family History of Hearing Loss _____

Comments _____

Results

Degree of Hearing Loss	R	L
Normal (0-15 dBHL)	☐	☐
Minimal (16-25dBHL)	☐	☐
Mild (26-40 dBHL)	☐	☐
Moderate (41-55 dBHL)	☐	☐
Moderate-Severe (56-70 dBHL)	☐	☐
Severe (71-90 dBHL)	☐	☐
Profound (91+ dBHL)	☐	☐

Type of Hearing Loss	R	L
High Frequency	☐	☐
Low Frequency	☐	☐
Conductive	☐	☐
Sensorineural	☐	☐
Mixed	☐	☐

Middle Ear Function	R	L
Normal Tympanogram	☐	☐
Negative Middle Ear Pressure	☐	☐
Flat/Rounded Tympanogram	☐	☐
High Compliance	☐	☐
Low Compliance	☐	☐
Absent/Elevated Acoustic Reflexes	☐	☐
Large Physical Volume	☐	☐

Recommendations

☐ Family Physician Referral _____
☐ Otologic (E.N.T.) Referral _____
☐ Audiologic Reassessment After Medical Treatment _____
☐ Reassessment: _____
☐ Specialized Testing: _____
☐ Other: _____

☐ Hearing Conservation Measures
☐ Hearing Aid Repair
☐ Hearing Aid Trial
☐ Auditory Brain Response (ABR)

Summary/Comments _____

☐ **Noise Induced Hearing Loss Package provided to worker.** **Date** *(Year / Month / Day)*

WCB Billing Number	Telephone Number	Name and mailing address of service provider: (please print)
Date of Service *(Year / Month / Day)*	Fax Number	
Assessment Completed by: ☐ Initial Assessment (HL 01) ☐ Subsequent Assessment (HL 02)	Print Name:	
	Signature and Credentials:	
Invoice Number		

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.