PHYSICIAN'S REPORT OF HISTORY, EXAMINATION, AND RECOMMENDATION FOR HEARING AID

(To be filled out by physician only and sent along with TAR, Mc - 1449 report, and prescription to provider).

Completion of this form will expedite Medi-Cal Consultant's review required by Section 51319 of Title 22, California Administrative Code.

1. Name of Patient:________________________________ Medi-Cal ID#: __________________________________

2. Age: _______ Sex: ________ Birth Date: ______________ ENT Exam Date: ___________________ 20 ____

3. Diagnosis: Medical (Otological) Place of Exam: ____

4. Patient has had a hearing loss: AD [ ] AS [ ] AU [ ] (Check applicable box(es))
   Since __________________ Due To ____

5. Has patient ever worn a hearing aid? Yes [ ] No [ ]

6. Patient has worn a hearing aid for _________ years on the ________ ear.

7. Tinnitus: Yes [ ] No [ ] If yes, Type __________ Ear __________ AD [ ] AS [ ] AU [ ]

8. Other physical and / or MENTAL IMPAIRMENTS that would affect this patient's use of a hearing aid and ability to adapt to its uses (Contraindications for an ear mold, general ability to manipulate and be responsible for a hearing aid).

   ____

   ____

9. What medical and / or surgical treatment has been performed in the past relative to the hearing impairment?

   ____

   ____

10. Does patient have any medically or surgically correctable conditions or one requiring further evaluation? If yes, describe.

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11. The audiological evaluation has been performed by me: __________________________ (Name), or a licensed audiologist ____________________________ (Name), or by personnel under my supervision ____________________________ (Name).

12. This patient has had a complete examination of the ear, nose, and throat by me, and has the requisite psychological and physical well being to successfully wear and care for a hearing aid. Yes [ ] No [ ]

13. SIGNATURE: ____ M.D. Print name and address below:
    Otolaryngologist / Personal Physician

____
Name

____
Address

____
City / State / Zip