

Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:

- a. Within Normal Limits Yes No
- b. Cerumen Removed Yes No
- c. Describe Ear Abnormalities:

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? Yes No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? Yes No

If yes, a hearing aid is medically prohibited in Right Ear Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? Yes No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

This form and supporting documentation must be maintained in the client's file.

A new Physician's Examination Report must be completed any time there is a change in the client's hearing or a new hearing aid is needed.