Australian Government

Comcare

HEARING AID REQUEST

1. EMPLOYEE'S PERSONAL DETAILS

Surname

Given names

Claim number

Date of birth

2. TREATING AUDIOLOGIST/AUDIOMETRIST/ENT SURGEON DETAILS

Name

Practice

Address

Telephone number

Provider number

Email address

Signature

Date

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)

Manufacturer and Model of current aids. Rationale to replace current aid(s), if appropriate.

Please attach a copy of the test results to this form including audiograms, speech audiometry and tympanometry.

1.	
2.	
3.	
4.	
5.	
6.	

3. 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.	

4. 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 the Department of Health and Aged Care Commonwealth Hearing Services Voucher Program, that meet the employee's needs? Free to client device list 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.

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

   Model number

   Model name (in full)

   Price

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

   Model number

   Model name (in full)

   Price

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)

SUBMISSION

Click here to save/submit form and any supporting information. Alternatively, you can email: general.equiries@comcare.gov.au or mail: Comcare, GPO Box 9905, Canberra ACT 2601

NEED ASSISTANCE?

If you have any questions or require assistance completing this form, please contact us via phone: 1300 366 979 or email: general.enquiries@comcare.gov.au

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