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| Texas Workforce Solutions logo | **Texas Workforce Commission****Vocational Rehabilitation Services****Hearing Evaluation Report****Otological Examination** |
| **Instructions**  |
| To be completed by an otolaryngologist, otologist, or licensed physician.  The information requested is necessary to help counselors determine eligibility or a plan for rehabilitation services for the person named.   All fields must be completed except where indicated as optional.   |
| **Participant/Customer Information**   |
| Customer Name:       | Case ID:       |
| Phone:       | Date of birth:       |
| **Otological Examination Report**   |
| Please return the report to:   |
| Name:       |
| Address:      | City:      | State:TX | ZIP Code:      |
| Reported disability:       |
| Reason for referral:       |
| **Otological Findings**   |
| History (check all that apply):  [ ]  Bacterial meningitis[ ]  Craniofacial anomalies (describe):      [ ]  Other (specify):       |
| Examination (check one): [ ]  Normal Ear [ ]  Abnormal EarIf abnormal, explain:       |
| Diagnosis:      |
| Based on (check one): [ ]  Pure Tone audiometry [ ]  OtherExplain other:       |
| Based on history and current exam, hearing loss is (check all that apply):   |
| [ ]  Progressive[ ]  Conductive | [ ]  Stabilized[ ]  Sensorineural | [ ]  Temporary[ ]  Mixed | [ ]  Permanent[ ]  Central | [ ]  Fluctuating |
| **Recommendations**   |
| Medical clearance for hearing aid:  Right ear: [ ]  Yes [ ]  No Left ear: [ ]  Yes [ ]  No |
| Is bone conduction hearing aid permissible? [ ]  Yes [ ]  No |
| Medical treatment or further comments:      |
| Precautions regarding training or working conditions:      |
| Physician’s printed name:       |
| Physician’s signature:**X**       | Date examined:       |