# BC Early Hearing Program

A service of BC Children's Hospital
and the Provincial Health Services Authority

# REQUEST FOR MEDICAL APPROVAL AND AUTHORIZATION FOR FITTING OF HEARING EQUIPMENT

| **Patient information** | |
|---|---|
| Patient name:<br><br>Address: Phone number:<br><br>Parent(s)/Guardian(s): | Date of birth:<br><br>Provincial health number:<br><br>BCEHP number: |

| **Audiological assessment information** | **Audiologist completing the request** |
|---|---|
| **Hearing loss type and degree:**<br>• Right ear:<br>• Left ear:<br><br>**Audibility levels (if known):**<br>• Right ear:<br>• Left ear: | Name:<br><br>Signature:<br><br>Date: |
| **Hearing aids are recommended for:**<br>☐Y ☐N Right ear:<br>☐Y ☐N Left ear: | **Please return the signed form to**<br>Audiology clinic name:<br><br>Fax number: |
| **Otolaryngologist authorization** | **Otolaryngologist completing the request** |
| ☐ **Approved as requested**<br>☐ **Not approved. Reason** _____<br>*The signing physician is responsible for arranging and ensuring medical referral, and for ensuring that the medical assessment of this child is completed as per BCEHP Medical Assessment Guidelines for Children with Sensorineural Hearing Loss.* | Name:<br><br>Signature:<br><br>Date: |

***Medical clinic support staff**: Please fax this signed approval form to the public health audiology clinic indicated above in order to authorize the audiologist to initiate fitting of appropriate hearing devices as indicated. Delays in medical approval will delay the access to amplification for the infant or child.*

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