**Department of Workforce Development**

**Division of Vocational Rehabilitation**

[CONTACT NAME]

[CONTACT INFORMATION 1

[CONTACT INFORMATION 2

[CONTACT INFORMATION 3

[CONTACT INFORMATION 4

**Tony Evers,** Governor

**Amy Pechacek,** Secretary

Dear Audiologist:

[INSERT NAME] is being referred by the Wisconsin Division of Vocational Rehabilitation (DVR) to assess their functional hearing abilities. In order to better serve our consumers please complete the following form.

**AUDITORY ASSESSMENT:**Based on the findings of the audiogram, [INSERT NAME] has:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Normal Hearing |  | Left ear |  | Right ear |  | Both ears |
|  | Mild Hearing Loss |  | Left ear |  | Right ear |  | Both ears |
|  | Moderate Hearing Loss |  | Left ear |  | Right ear |  | Both ears |
|  | Severe Hearing Loss |  | Left ear |  | Right ear |  | Both ears |
|  | Profound Hearing Loss |  | Left ear |  | Right ear |  | Both ears |

**VOCATIONAL LIMITATIONS** (check all that apply)**:**

|  |  |
| --- | --- |
|  | Difficulty hearing 1:1 conversations |
|  | Difficulty hearing group meetings |
|  | Difficulty identifying emergency sounds (i.e. fire alarms) |
|  | Difficulty communicating over the phone |
|  | Difficulty hearing in noisy environments |

[INSERT NAME] currently utilizes the following to address his/her hearing loss (check all that apply):

|  |  |
| --- | --- |
|  | Hearing aids – Make/Model |
|  | Amplified Phone/Captioned Telephone |
|  | Closed Caption on TV, computer, and/or smart phones |
|  | FM System/Neck Loop |
|  | Environmental modifications (i.e. increased lighting, quiet work spaces, strobe emergency alarms) |

**WORKPLACE ACCOMMODATIONS RECOMMENDED** (check all that apply)**:**

|  |  |
| --- | --- |
|  |  |
|  | Assistive Listening Devices (i.e. phone amplification, captioned phones, FM systems) |
|  | Modification of Non-Essential Duties |
|  | Emergency Notification System (i.e. strobe lights on fire alarms, multiple frequency alarms) |
|  | Position Reassignment |

**RECOMMENDATIONS:**

**Do you accept the Medical Assistance Rate?  YES  NO**

**HEARING AID/ACCESSORIES RECOMMENDATION(S):**

**Make/Model: ­­­­**

*Please attach an itemized quote including all services and/or accessories recommended to address consumers auditory functional limitations.*

**HEARING CARE INFORMATION:**

What is the life expectancy of the devices you're recommending?

What steps should I take to properly take care of my hearing devices?

How much are hearing aid batteries and where are they sold? How often do they need to be replaced on average?

How should I clean ear wax from my ears?