CLEVELAND Hearing & Speech CENTER℠

○ 6001 Euclid Avenue Suite 100 · Cleveland, OH 44103 · 216-231-8787 · 216-231-7141 Fax
○ 5084 Mayfield Road · Lyndhurst, OH 44124 · 216-382-4520 · 216-325-7609 Fax
○ 7000 Town Centre Drive #200 · Broadview Heights, OH 44147 · 440-838-1477 · 216-325-7620 Fax
○ 29540 Center Ridge Road Suite B · Westlake, OH 44145 · 440-455-9898 · 440-455-1999 Fax

Medical Clearance for Hearing Aid Use form

Client _____ DOB _____ Date of Audio _____

Clinician _____ CHSC Program _____

Dx code _____ Right PTA _____ Left PTA _____

Written summary _____

PHYSICIAN: Please complete this form and return it to your patient or Cleveland Hearing & Speech Center/ Audiology Department (intake@chsc.org).

It has been recommended that the above-named client obtain hearing aid(s). The client is medically cleared for hearing aid and/or earmold use. The hearing aid(s) are considered medically necessary.

Comments and/or reasons for medical contraindiction of hearing aid use:

I hereby attest that the statement above is true, correct and complete.

Physician Signature:_____

Physician's Name (Printed):_____

Physician NPI:_____

Address:_____

Telephone:_____

Date:_____