BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

VETERAN REFERRAL QUESTIONNAIRE:

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITY. THANK YOU FOR YOUR SERVICE.

1) Today's Date: _____
2) Name: _____
3) Date of Birth: _____
4) Age: _____
5) Gender (**CIRCLE ONE**): **Male** or **Female**
6) Primary Language: _____
7) Email Address: _____
8) Home Phone Number: _____ Cell Phone Number: _____
9) Address: _____

   City: _____ State: _____ Zip Code: _____
10) Current Employment (**CIRCLE ONE**):

    Full-Time **Part-time** **Retired** **Unemployment** **Stay at home** **Student**
11) Current Employer: _____
12) Position: _____
13) If retired, list Prior Ocupation: _____
14) Family Doctor: _____
15) Number of years in service: _____
16) Do you currently wear hearing aids (**CIRCLE ONE**): **Yes** or **No**

17) Do you feel you have a hearing loss (**CIRCLE ONE**): **Yes** or **No**
    a) If yes, in both ears? (**CIRCLE ONE**): **Yes** or **No**
    b) If not in both ears, which ear? (**CIRCLE ONE**): **Left** or **Right**

18) Do you have Dizziness or Unsteadiness (**CIRCLE ONE**): **Yes** or **No**
    a) If yes, do you have vomiting, nausea, or ear noises (**CIRCLE ONE**): **Yes** or **No**
    b) If yes, please explain: _____

19) Do you have Ear deformity (**CIRCLE ONE**): **Yes** or **No**

20) Do you have Ear drainage (**CIRCLE ONE**): **Yes** or **No**

21) Do you have Ear pain or History of ear infections (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain:_____

22) When was your last hearing test? _____

a) Where? _____

23) Is the Veteran Homeless (**CIRCLE ONE**): **Yes** or **No**

24) Did you bring your medical records or any information you'd like the VA to have that they do not have already (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

25) What is your main complaint (**CIRCLE ONE**): **Hearing Loss** **Tinnitus (ringing in the ears)** **Both**

a) Please explain Hearing Loss and Tinnitus Issues: _____

b) If something else, please explain: _____

26) When did your hearing loss start (**PLEASE LIST APPROXIMATE DATE**): _____

a) How did your hearing loss start? _____

27) What difficulties, if any, does the Veteran have with their hearing? (Examples: hearing is fine, able to hear but not clearly, difficulty in noisy or group environments)

a) **Please List**: _____

b) If something else, please explain: _____

28) Pertinent Military Service History (Evidence: DD214):

a) Branch of service: _____

b) MOS/Job in the Military: _____

c) Dates of service (**MONTH/YEAR if known**): _____ to _____

d) Pertinent decorations or medals or ribbons (**CIRCLE ANY THAT APPLY**): **Purple Heart, Combat Action Badge, Combat Infantry Badge, Meritorious Achievement Badge, AAM, Good Conduct Medal, Global War on Terrorism, Overseas Ribbon**

Please list any others if not listed: _____

29) Did you serve during Peace Time (**CIRCLE ONE**): **Yes** or **No**

30) Did you serve during Combat (**CIRCLE ONE**): **Yes** or **No**

31) Did you serve during Peace Time AND Combat (**CIRCLE ONE**): **Yes** or **No**

HISTORY OF MILITARY NOISE EXPOSURE:

32) Did you have Military Noise Exposure while you were in the service (**CIRCLE ALL THAT APPLY**):

Explosions Firearms Artillery Aircraft Noise Heavy Equipment Generators

a) Please list details of any other Military Noise Exposure:

_____

_____

33) Did your military job require you to be in noise (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

34) Did you wear ear protection (**CIRCLE ONE**): **Yes** or **No**

a) If no, why didn't you wear ear protection? (**PLEASE EXPLAIN**): _____

HISTORY OF OCCUPATIONAL NOISE EXPOSURE (Examples: Aircraft, Farm Equipment, Heavy Equipment, Power Tools, Etc.):

35) **BEFORE** you were in the service did you work around noise (**CIRCLE ONE**): **Yes** or **No**

a) **If yes, please explain**: _____

36) **AFTER** you were in the service did you work around noise (**CIRCLE ONE**): **Yes** or **No**

a) **If yes, please explain**: _____

HISTORY OF RECREATIONAL/ SOCIAL NOISE EXPOSURE:

37) **BEFORE** you were in the service were you exposed to Recreational/Social Noise?

(**CIRCLE ALL THAT APPLY**): **Motorcycles ATV Firearms Power tools Music None**

List any other recreational noise exposure not listed: _____

38) **DURING** your time in the service were you exposed to Recreational/Social Noise?

(**CIRCLE ALL THAT APPLY**): **Motorcycles ATV Firearms Power tools Music None**

List any other recreational noise exposure not listed: _____

39) **AFTER** you were in the service were you exposed to Recreational/Social Noise?

(**CIRCLE ALL THAT APPLY**): **Hunting Motorcycles ATV Firearms Power tools Music None**

List any other recreational noise exposure not listed: _____

FAMILY HISTORY OF HEARING LOSS:

40) Does anyone related to you have hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please list relation (Example: mother, father, uncle, grandfather or grandmother, etc.)

_____

_____

HEARING LOSS:

41) Have you had a surgery that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

42) Have you had chemo/ radiation treatments that have caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

43) Have you had head trauma that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

44) Have you taken long-term IV antibiotics that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

45) Have you had an acoustic neuroma (ear tumor) that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

46) Does hearing loss affect your daily activities? Examples: Phone calls, Difficulties in background noise, Conversations with others, TV is louder, etc. (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

47) What daily life hearing difficulties do you have?

_____

48) How does hearing loss affect your work environment?

_____

49) Do you have tinnitus (i.e. ringing in the ears, humming, rushing, buzzing, clicking)? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please **CIRCLE ONE**: **Constant** or **Intermittent (off & on)**

b) If yes, what do you think caused your tinnitus? _____

c) If yes, what date did the tinnitus start (can be approximate date) _____

d) If yes, describe how often (times per day, month, week) you have tinnitus _____

50) Does your tinnitus affect daily activities (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain (Examples: Phone calls, daily tasks, sleep, conversations with others)

_____

51) Does your tinnitus (ringing in the ears) affect your work activities (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please describe how: _____

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HIPAA/Communication/Consent to Treatment

Our Notice of Privacy Practices provides information about how we may use and disclose protected information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting Baker Audiology.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy dated August 13th, 2018.

Communication with Family and Friends

Baker Audiology may share medical and/or billing information with the following individuals who are involved with the patient's care:

Release to:_____ Relationship:_____

Release to:_____ Relationship:_____

Wireless Communications

I hereby agree that by providing my wireless/cell phone number, I am, hereby granting my consent to receive communication on my wireless/cell phone number for business related to my healthcare services or payment thereof. Methods of contact may include messages on your phone directly from our office on your voicemail and text messages.

◯ Decline

Authorization for Treatment

I consent to treatment for myself or my family from Baker Audiology & Hearing Aids:

Signature of patient:_____

Printed name of patient:_____

Signature of representative if other than patient:_____

Printed name of representative if other than patient:_____

Relationship to patient:_____

Time:_____

Date:_____

Order number (OFFICE USE ONLY): _____

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Policy, VA/LHI/VES billing and release of medical records Authorization, Notice of privacy practices acknowledgment of receipt and Veteran Authoriazation of Disclosure:

*We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.

Please initial_____

*I request that payment of authorized benefits be made on my behalf to Baker Audiology & Hearing Aids for services furnished to me by the provider. I authorize any holder of medical information about me to release to Baker Audiology & Hearing Aids. Any information needed to determine these benefits or the benfits payable for related services.

Please initial_____

*I hereby authorize you to Release, to my attorney(s) and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.

Please initial_____

*I acknowlege that I have been given the opportunity to read the notice of privacy practices for the office of Baker Audiology & Hearing Aids. A copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Please initial_____

*In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual's home. The Veteran may revoke or change this authorization at any time with a written request.

Please initial_____

*In further efforts to protect your health information and confidentiality of your healthcare, we ask that you designate below to whom the staff may discuss your healthcare and scheduling needs as well as being issues that may arise.

Please list any **Name, relationship and phone numbers** of the designated people:

_____

_____

_____

Signature of Veteran:_____

Signature of Parent or Guardian: _____

Date:_____