

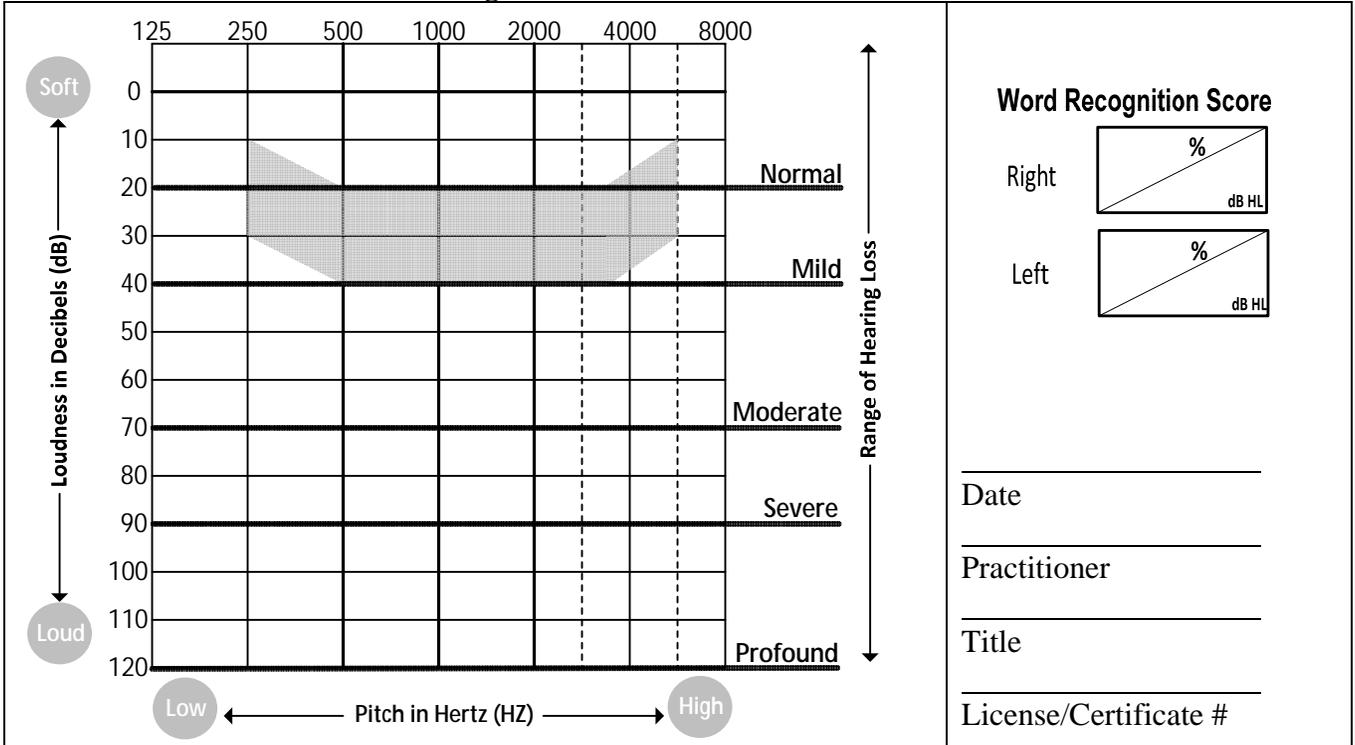
Business / Clinic Name  
 Address 1  
 Address 2  
 Phone

Practitioner: \_\_\_\_\_  
 License / Certificate No.: \_\_\_\_\_  
 Email: \_\_\_\_\_

**CLIENT HEARING EVALUATION & HEARING INSTRUMENT RECOMMENDATION**

Client Name:	Date:
Client Address:	Client Physician:

**Audiogram**



Consumer Rights	Practitioner Recommendation
<input type="checkbox"/> Client was given MDH brochure on legal rights and consumer information about purchasing a hearing instrument.  <input type="checkbox"/> Client was given a copy of the audiogram.	All 8 FDA Criteria met to recommend hearing instruments? <input type="checkbox"/> Yes <input type="checkbox"/> No  Recommend hearing instruments? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Binaural

Hearing Instrument Options / Prices / Services		
Trade Name or Brand/ Style/Model	Price Options	Service Options

**THIS PRESCRIPTION OR RECOMMENDATION MAY BE FILLED BY, AND HEARING AIDS MAY BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE**

**U.S. Food and Drug Administration Informed Consent Medical Waiver**

I have been advised by \_\_\_\_\_ that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish to have a medical evaluation before purchasing a hearing aid.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_