

Hearing Loss Prescription (HeLP) Form

Patient Name _____ Date of Clinical Encounter _____

Have the patient rate each item on a three-point scale (1=no difficulty, 3=significant difficulty), at baseline and at post-treatment.

Difficulty understanding family members

Baseline _____ Post treatment _____

Difficulty communicating with health care professionals

Baseline _____ Post treatment _____

Difficulty understanding conversation in a group setting

Baseline _____ Post treatment _____

Difficulty understanding in noisy situations

Baseline _____ Post treatment _____

Difficulty understanding conversation over the telephone

Baseline _____ Post treatment _____

Family members complain that hearing loss affects routine conversation

Baseline _____ Post treatment _____

Communicating with others is tiring

Baseline _____ Post treatment _____

Recommendations:

Hearing aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearables	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing assistive technology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Communication strategies	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Next Steps:

Ear wax removal: Yes No

Medical clearance: Yes No

Return to audiologist in _____ weeks

Audiologist name: _____

Audiologist phone number: _____