



information on eye care and vision
for people with learning disabilities

Feedback from the Hearing Specialist about my Hearing Test

To be completed by Hearing Specialist and given to the person

Name of person being tested

Address

Date of Birth

**Date of Hearing
Test**

NHS Number

**Name of Hearing
Specialist**

**Name of Hearing
Service**

**Hearing Service contact
details**

**Name and contact
details of supporter
accompanying person
to test**

**Has a hearing loss or difficulty been detected?
(Please describe)**

Please describe how the person's hearing loss or difficulty might affect them

Please describe how others might need to support the person (such as learning new communication skills, the volume they may need to speak, the resources the person may need etc.)

Has ear wax been noted as a concern?	YES		NO
Any recommendations regarding ear wax?			
Was full examination possible? (Y / N) If no, why? (e.g., Lack of time, facilities, difficulties with procedures etc.)			
Has the person been issued with Hearing Aids?	YES		NO
Please tell us more The person may require significant support in becoming familiar with wearing aids or operating controls: The person may require significant support in adjusting to digital hearing aids: Were ear mould impressions taken at the time of the hearing test?			

What advice has been given to the person and their supporter regarding the introduction, use and maintenance of the aids?

Is the person to be referred on to any of the following?

GP / Consultant / Speech and Language Therapist / Hearing Therapist / Occupational Therapist / Social Worker / Local d/Deaf Association / Other? (Please state)

Who needs to make this referral?

Any other comments? (Please state)			
How often should the person receive a Hearing Test?			
When is their next Hearing Test due?			
Will a reminder be sent?	YES	NO	

**Hearing Specialist's
Signature**

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**Hearing Specialist's
Printed Name**

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