Reconnect with your world

All About Hearing
Hearing Health Care Professionals

Client (Child) Contact Information and Consent

Title (Please Circle): Master / Miss

First Name: _____ Last Name: _____

Date of Birth: _____ / _____ / _____

Parent or Guardian's Name: _____

Residential Address: _____

Town/Suburb: _____ State: _____ Postcode: _____

Phone (Home): _____ Mobile: _____

Email: _____

Preferred Contact Method (please tick): ☐ Home Phone ☐ Work Phone ☐ Mobile ☐ Email ☐ Mail

☐ Yes - I would like a copy of my child's results sent to his / her doctor

Doctor's Name: _____

Doctor's Email: _____ Doctor's Phone: _____

Doctor's Address: _____

Town/Suburb: _____ State: _____ Postcode: _____

☐ Yes, I have a referral

How did you hear about us?: _____

(continue over page)

Information and Consent

Please turn off all mobile phones as they will Interfere with our testing. Thank you.

Please complete all of the questions that follow:

1. Do you have concerns about your child's hearing?	YES	NO
- If yes, how long have you had these concerns? Indicate duration (mths or yrs)		
2. Does your child's teachers have concerns about your child's hearing?	YES	NO
- If yes, how long have you had these concerns? Indicate duration (mths or yrs)		
3. Were there any problems during pregnancy?	YES	NO
4. Were there any problems during delivery?	YES	NO
5. Has your child had any previous hearing tests?	YES	NO
6. Does you child currently have a cold/flu/virus?	YES	NO
7. Has your child had any ear infections, ear discharge or ear problems?	YES	NO
- If yes, when was the last one? Indicate duration (mths or yrs)		
8. Has your child had any upper respiratory infections?	YES	NO
- If yes, when was the last one? Indicate duration (mths or yrs)		
9. Has your child had any ear, nose or throat operations?	YES	NO
10. Has your child had any head injuries or ear trauma?	YES	NO
11. Do any of your family members have or were born with a hearing loss?	YES	NO
12. Do you have any concerns about your child's motor/physical development?	YES	NO
13. Do you have any concerns about your child's speech/language development?	YES	NO
14. Does your child have any diagnosed disabilities?	YES	NO
- If yes, please let us know:		

I _____ (parent/guardian) consent to the following procedure/s performed at the cost below and permission is given for reports to be sent to my child's doctor allied health care practitioner.

Cost $: _____

- I agree to pay the above fees on the day of service.
- I understand that if medical advice is needed that I need to see my medical practitioner.
- I understand that all records are confidential and governed by the Privacy Act. I agree that the results of these tests will be provided to the referring agent, doctor or allied health care practitioner.

SIGNED: _____ DATE: _____