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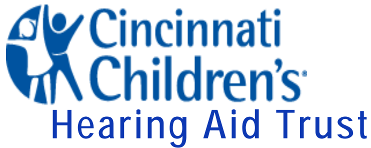

CCHAT

CCHMC Hearing Aid Request Form

Audiologist's Name: ______________________________

Practice Street Address: ______________________________

City/St/Zip: ______________________________ County: ______________________

Phone: ______________________ Fax: ______________________

Have you taken a patient through CCHAT before? ☐Yes ☐If not, please submit a Provider Application.

Managing Physician's Name: ______________________________

Parent/Guardian Information

Parent Name(s): ______________________________ Email: ______________________________

Parent Address: ____

City/State/Zip: ______________________________ County: ______________________

Home #: ______________ Cell #: ______________ Work #: ______________ Fax #: ______________

Patient Information

Patient Name: ______________________________ Date of Birth: ______________ ***MRN#:** ______________

Hearing Loss

In which ear is a hearing device being requested: ☐Left ☐Right ☐Both

Has child been fit with amplification on a trial basis? ☐Yes ☐No

Testing

Please include a copy of the current audiogram taken within 6 months, physiologic test results, physician visit forms and any other pertinent audiological information needed for diagnosis with this request.

Anything else we should know?

____

____

Hearing Aids

We provide hearing aids from Oticon and Phonak. All aids also come with a Patient Care Kit. Please select your model preference:

Oticon Account #: ____________________ PO#__________________

SAFARI: ☐ 300 ☐ 300 POWER ☐ 300 SUPER POWER

Phonak Account #: ____________________ PO #:_________________

CASSIA:	☐ MICRO M	☐ MICRO P	☐ SP	☐ PETITE
CERTENA ART:	☐ M	☐ P	☐ SP	☐ MICRO PETITE
NAIDA:	☐ III UP DAZ	☐ III SP DAZ	☐ S III SP	☐ S III UP
NIOS:	☐ MICRO III			
MILO PLUS:	☐ SP	☐ UP	☐ MICRO	
OK! PLUS:	☐ SP	☐ UP	☐ M	

COLOR: ________________ BATTERY SIZE: _______________ TP DOORS: ☐ YES ☐ NO PEDIATRIC EAR HOOKS: ☐ YES ☐ NO

Contact information to where hearing aid(s) should be delivered:

Name: ____

Address: ☐ Same practice as above; if not: ____

By printing your name below, you affirm that the information contained within this application is current and complete. If a change in any information occurs, please notify CCHAT immediately. Additionally, I grant permission to the Cincinnati Children's Hearing Aid Trust to release all medical records pertaining to my patient's hearing disorders to the assigned CCHAT Coordinator for the purposes of applying for alternative financial assistance.

Audiologist Signature: ______________________ Print: ___________________________ Date: _____________

******After completing form entirely, please save a copy as "(Patient's First and Last Name) CCHAT Request". Example: Cali Rhein's CCHAT Request. Attach document in e-mail and send to: Cali.Rhein@cchmc.org. If you have any questions please contact: Cali Rhein at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Cali Rhein or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Cali Rhein, 3333 Burnet Avenue, MLC 2018, Cincinnati, OH 45229-3039.******

The Cincinnati Children's Hearing Aid Trust reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.

Updated: 07/2011