The Cochlear Implant Team

Cochlear Implant Evaluation Intake Form

Patient Name: ______________________

Date of Birth: ______________________

MRN: *(Office use only)* ______________________

Date: ______________________

Name of person completing this form: ______________________ Relationship to patient: ______________

1. FAMILY INFORMATION

	Parent/Legal Guardian	Parent/Legal Guardian
Name:		
Date Of Birth:		
Address:		
City/State/ZIP code:		
Phone:		
Email:		
Occupation:		
Place of Employment:		

List names and ages of those who live in the household:	

Does this child have a foster parent or legal guardian? ☐ Yes ☐ No

If yes, is the foster parent/legal guardian a relative? ☐ Yes ☐ No

In order to better support your family as you investigate cochlear implantation, please complete the following:

Do you have any concerns with the following?	YES	NO		YES	NO
Reliable transportation	☐	☐	Family members agreeing with the decision to pursue a cochlear implant	☐	☐
Insurance coverage	☐	☐	Support in coping with your child's hearing loss	☐	☐
Finances	☐	☐	How your child will perform with a cochlear implant	☐	☐
Providing for your family	☐	☐	Types of available education or therapy support in your area	☐	☐
Employer's support for time off to attend appointments	☐	☐			

How would you describe the level of stress in your family? ☐ Unbearable ☐ High ☐ Average ☐ Low

What concerns you most about your child currently? ______________________

____

Tell us what you hope a cochlear implant will do for your child? ______________________

____

Please list your thoughts about what it takes to make cochlear implants successful? ______________________

____

What do you think is a "poor" cochlear implant outcome? ______________________

____

How long do you think it will take to receive benefit from the implant? ______________________

What do family and friends think about the implant? ______________________

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2. HEARING HISTORY

If **not** CCHMC, where was your child's hearing loss diagnosed?	
Other than CCHMC, where has your child's hearing been tested?	
When was your child's hearing loss diagnosed?	☐ Birth ☐ Later, list age: ________ ☐ Before talking ☐ After talking
Over time did your child's hearing loss:	☐ Stay the same ☐ Become worse
Is there a big difference in the amount of hearing loss between ears?	☐ Yes ☐ No
What caused your child's hearing loss? ____________________	

- **HEARING AIDS**

At what age did your child start wearing hearing aids?	☐ Birth – 6 months ☐ Later, list age: ________
How long has your child worn hearing aids?	☐ More than 3 months ☐ Less than 3 months
Does your child wear them during all waking hours, most of the time, or reject wearing them?	☐ Reject ☐ Wear them some of the time ☐ Wear them full time
Do hearing aids seem to help your child?	☐ Not really ☐ Can't tell ☐ Some ☐ A lot, but not enough
How important is it to you that your child wears his/her hearing devices during all waking hours?	☐ Very important ☐ Somewhat important ☐ Not that important
How far away can you be and your child still appears to hear you?	☐ 3 ft. (arm's length) ☐ 6 ft. (across table) ☐ 12 ft. (another room) ☐ unable to hear
Do hearing aids seem to help your child hear soft sounds (whispers)?	☐ Yes ☐ No
Does your child learn best by overhearing or by watching others?	☐ Overhearing ☐ Watching others
Do hearing aids help your child understand speech?	☐ Yes ☐ No

- **COCHLEAR IMPLANTS** *(Skip if not applicable)*

At what age did your child receive a cochlear implant?	☐ 12 months or less ☐ Later, list age: ________ ☐ Before talking ☐ After
How long has your child had the cochlear implant?	☐ More than 6 months ☐ Less than 6 months
Does your child wear a hearing aid in the opposite ear?	☐ Yes ☐ No
How long did it take to adjust the sound of the new device? Did anything help them adjust? ____________________	☐ Immediately ☐ Approximately a month ☐ By the third MAP ☐ 6 months
Does the cochlear implant seem to help your child?	☐ Uncertain ☐ Some, but not enough ☐ Significantly
How important is it to you that your child wears their hearing devices full time?	☐ Very important ☐ Somewhat important ☐ Not that important
Does the cochlear implant help your child hear distant sounds?	☐ Yes ☐ No
Does the cochlear implant help your child hear soft sounds (whispers)?	☐ Yes ☐ No
Does your child learn best by overhearing or by watching others?	☐ Overhearing ☐ Watching others
Does the cochlear implant help your child understand speech?	☐ Yes ☐ No

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3. COMMUNICATION HISTORY

What do you feel is important to know about your child and how he/she communicates? ______________________

____

How does your child communicate with you and members of your family (i.e., speech, sign language, gestures)?

____

What are your communication goals for your child? ______________________

____

What communication intervention are you receiving at this time? ______________________

What goals are being addressed in intervention? ______________________

How involved are you or other family members in therapy sessions? ______________________

How do you incorporate therapy techniques at home? ______________________

____

4. SCHOOL HISTORY/EARLY INTERVENTION/THERAPIES

Is your child enrolled in:	
Early Intervention ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Daycare ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
School ☐ Yes ☐ No ☐ Preschool ☐ Elementary School ☐ Middle School	Where/How often:
☐ High School ☐ Home School	Contact name/phone #:
Private Speech Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Private Occupational Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Private Physical Therapy ☐ Yes ☐ No	Where/How often:
	Contact name/phone #:
Other: ______________	Where/How often:
	Contact name/phone #:

Is your child mainstreamed with typical-hearing students? ☐ Yes ☐ No ☐ Unsure

Does your child have an interpreter in the classroom? ☐ Yes ☐ No ☐ Unsure

Does your child have an Individualized Education Plan (IEP) or 504? ☐ Yes ☐ No ☐ Unsure

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5. MEDICAL HISTORY

Have any other family members had trouble with their hearing at a young age? ☐ Yes ☐ No

If so, please explain: ____________________

Does your child have any of the following developmental/medical conditions besides hearing loss, which may change their rehabilitation path with cochlear implants?

☐ Cytomegalovirus (CMV)	☐ Genetic disorder	☐ Meningitis
☐ Cerebral Palsy (CP)	☐ Autism	☐ Family history of migraines
☐ Down syndrome	☐ Hydrocephalus w/ shunt	☐ Heart problems
☐ Bleeding disorder	☐ Neurofibromatosis	☐ Cancer
☐ Immunosuppressed	☐ Cochlear malformation	☐ Brain abnormalities
☐ CHARGE syndrome	☐ Head noise/ringing in ears	☐ Balance/coordination problems

Did your child have any problems at birth or need to be hospitalized immediately following birth? ☐ Yes ☐ No

If so, please explain: ____________________

____

Has your child had any significant illnesses that required hospitalization? ☐ Yes ☐ No

If so, please describe, including age of onset: ____________________

____

Has your child ever had surgery? ☐ Yes ☐ No If so, at what age? ____________________

If so, what surgeries were completed? ____________________

____

Did your child have a genetics work up? ☐ Yes ☐ No

If so, what were the results? ____________________

Did your child have a MRI or CT scan? ☐ Yes ☐ No

If so, what were the results? ____________________

IMMUNIZATION HISTORY:

If your child is between the ages of 0-2 years, has he/she completed the Prevnar® vaccine series?

☐ Yes If yes, please include a copy of the immunization records.

☐ No If no, your child needs this vaccine prior to Cochlear Implant surgery.

If your child is over the age of 2, has he/she received the Pneumovax® 23 vaccine?

☐ Yes If yes, please include a copy of the immunization records.

☐ No If no, your child needs this vaccine prior to Cochlear Implant surgery.

Office use only:

Form received by: ____________________

Signature/Credentials Printed Name Date/Time