

Children's Hearing Center of East Tennessee

* John P. Little, M.D. **Board Certified**

Suite 410

Knoxville, TN 37916

865-521-6005 fax 865-521-6088 A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Medical Release

Fellowship Trained		Medical Release	
Board Certified Fellowship Trained	Patient: Date of Birth: Chart:		
R. Mark Ray, M.D. Board Certified Fellowship Trained	insurance carriers and other	s ENT Specialists to furnish a health providers/facilities con may be furnished and obtaine	cerning my child's illness
Kristie Johnston, Au.D. CCC-A Holly North, M.A. CCC-A Kristi Walden, Au.D. Pediatric Audiologists	Name of provider/facility	Location	Phone number
Samantha Wallenstein, M.S. Audiology Extern Janet L. Harris Office Manager			
* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital			
Children's Hospital	Printed Name of Parent	Signature of Parent	Date
2100 Clinch Avenue	Printed Name of Witness	Signature of Witness	Date

This request is valid for this release only

FISHER'S AUDITORY PROBLEMS CHECKLIST

Student Name		District/Building			
Date	Grade	Observer	Position		
Please place a che	ock mark before each ite	m that is considered to be a	concern by the observer:		
	vivi				
The second secon	story of hearing loss.				
	story of ear infection(s).		Lascomonia de la comonia de la		
		instruction 50% or more of			
		ctions - often necessary to re			
		st five or more times per day			
		i for more than a few second	ls.		
	ort attention span.		The second section is a second section of the s		
	em is checked,	0-2 minutes	5-15 minutes		
	k the most	(Age 5.0 - 5.11)	And the control of th		
	ate time frame.)	2-5 minutes	15-30 minutes		
	ns - attention drifts - no				
	distracted by backgroun	id sound(s).			
	culty with phonics.	(ILC - 0.2 ogA)			
	ces problems with soun		. AND		
the state of the s	hat is said in a few min				
		ne things from day to day.			
		t was heard last week, month	n, year.		
	culty recalling a sequence				
	ces difficulty following				
	y misunderstands what				
		ds - verbal concepts for age/	grade level.		
	orly through the auditor	- Contract of the Contract of			
		ology, syntax, vocabulary, ph	nonology).		
	iculation (phonology) p				
	ways relate what is hear	d to what is seen.			
23. Lacks mot					
	low or delayed response				
25. Demonstra	ates below average perf	ormance in one or more aca	demic area(s).		
coring: Four perce	nt credit for each numb				
		: checked x 4 =			
	Normative data - gra	de score from reverse side _	I doold sais:		

This form must be completed in full. Please do not send charts, narratives, and/or diagrams as they will be returned



Tennessee Department of Health Newborn Screening Follow Up Program 1st Floor, R.S. Gass Building 630 Hart Lane, Nashville, Tennessee 37243 Phone (855) 202-1357 Fax (615) 532-8555

Audiology Hearing Screen and/or Diagnostic Evaluation Results

Child's	Last Name F	irst Name	Middle Name	Gender	(Twin: A or B)	Date of Birth
Birth M	lother's Last Name	First Name	Maio	den Name	Sta	te Lab TDH#
Address	s	City		State/Zip		Phone
Primary	/ Care Provider Full Name	Phone			Foster Parent	Name if Applicabl
Birth Ho	ospital Name:			City/State	:	
	f Evaluation:					
	f Evaluation: □ABR/		Tymp/Reflex [havioral stic results at bot	tom of page)
Res	sults: R: □Pass □Ref	er L: □Pass □Re	fer			,
Only m	ark one below:					
	Results are INCONCLU	SIVE. Please do not	mark hearing loss	if results are II	NCONCLUSIVE	
	Probable Acute Fluctua Re-Evaluate on:	ating Conductive HL-	No TDH Referral	s needed at thi	s time	
NOTE:						
•	If hearing loss is marke	d below, referrals for	or TEIS, CSS and F	amily Support	WILL BE MADE.	
	Diagnostic Results: No	rmal Limits (0-15dB)	□R □L or Hear	ing Loss □R □	L (if HL provide	degree and type)
	ii iicai iiig Loss, Deg	ree (please mark):	If Hear	ing Loss, Type	(please mark):	acgree and type)
	Slight Mild	(16-25dB) □R □	L Unspe	cified HL		□R □L
	Moderate	(26-40dB) □R □		c Fluctuating C	onductive HL	\Box R \Box L
	Moderately Severe	(41-55dB) □R □ (56-70dB) □R □		nent Conductiv	e HL	□R □L
	Severe	(71-90dB) □R □				□R □L
	Profound	(91+dB) □R □		ineural HL (inclu	iding Fluctuating)	□R □L
		(52.05)	- Audito	ry Neuropathy,	/Dyssynchrony	
Commer	nts/Follow-Up:					
	Provider Name					
Facility/F	Provider Name:	Company of the Compan	City		Phone	
Facility/F	Provider Name:tors: (see below, check all	that apply)	City	/:	Phone	
Facility/Fac	Provider Name:tors: (see below, check all	that apply) 4	City	/: □ B □ C		
Facility/F	Provider Name: tors: (see below, check all 2 3 IICU > 5 days yndrome associated with progre	that apply) 4	City	/:B C	Phone	
Facility/F Risk Fact 1. N 2. S 3. F	Provider Name:tors: (see below, check all 2 3 all CU > 5 days and yndrome associated with progressianily history of permanent child	that apply) 4	City A. Che B. Assi	/: C motherapy sted ventilation	Phone	
Facility/F Risk Fact 1. N 2. S 3. F 4. C	Provider Name: tors: (see below, check all 2	that apply) 4	City A. Che B. Assi C. Otol , ear canal, D. Hyp	B C motherapy sted ventilation toxic medications or erbilirubinemia requ	Phone	E
Facility/F Risk Fact 1. N 2. S 3. F 4. C e 5. In	Provider Name:tors: (see below, check all 2 3 all CU > 5 days and yndrome associated with progressianily history of permanent child	that apply) 4	City A. Che B. Assi C. Otor , ear canal, D. Hyp E. Phys	B C motherapy sted ventilation toxic medications or erbilirubinemia requisical findings such as	Phone	E F



Children's Hearing Center of East Tennessee

* John P. Little, M.D.

Board Certified
Fellowship Trained

A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Unsedated/Sleep Deprived ABR Instruction

Aichael J. Belmont, M.D. Board Certified Fellowship Trained

> R. Mark Ray, M.D. Board Certified Fellowship Trained

Kristie Johnston, Au.D.
CCC-A
Nicole Johnson, Au.D.
CCC-A

Alison Ward, M.S. Pediatric Audiologists

> Janet L. Harris Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital ledical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916

> 865-521-6005 fax 865-521-6088

An Auditory Brainstem Response (ABR) test assesses hearing abilities to the level of the brainstem. This is done by measuring the brain's response to specific sound(s) presented to the ear. Total time for the procedure may be up to an hour and a half. The test is painless, but requires that the patient be sleeping and still. This is typically possible in infants less than six months old and children old enough to take a nap. Children older than 6months, or those who cannot sleep for the procedure in office, will have to be sedated.

In order to ensure the best results, and avoid sedation we ask that you:

- 1. Skip the usual feeding prior to test
- 2. Skip the usual nap/sleep time prior to test
- 3. Do not put lotion on your child's head prior to test.

When you arrive for the test, we will bring you to our test room where you may feed and rock your child to sleep. The lack of lotion ensures that our electrodes will stick to the skin and provide a better reading for our equipment. If you have any questions, you may feel free to contact our office at 865-521-6005

Patient Name:	DOB:
Scheduled ABR Date & Time:	
Cancelling, no-showing, or rescheduling the unsede your child due to the small age winde	ated ABR may result in having to sedate ow for unsedated testing.
I have read and understand what is require	ed for my child's unsedated ABR
Parent/Guardian Signature	Date
Witness Signature	Date



* John P. Little, M.D. **Board Certified** Fellowship Trained

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

Call O'R

(541-8128)

SEDATED ABR/BAER PHYSICIAN ORDER SEDATION SUITE____

lichael J. Belmont, M.D.	
Board Certified	Date:
Fellowship Trained	
	Patient Name:DOB:
R. Mark Ray, M.D.	Parent's Name(s):
Board Certified	Address
Fellowship Trained	Address:
Kristie Johnston, Au.D.	Primary Phone:
CCC-A	Primary Phone: Secondary Phone:
Holly North, M.A.	Insurance Carrier:
CCC-A Kristi Walden, Au.D.	Diagnosis
Pediatric Audiologists	Diagnosis:
	Physician (Please Print):
Samantha Wallenstein,	
M.S.	Physician Signature:
Audiology Extern	Discharge per Anesthesia protocol for Operating Room
Janet L. Harris	
Office Manager	Comments:
11 N	
* Implant Surgeon,	Appointment Date: @a.m./p.m.
Pediatric Cochlear	
Implant Program	Please schedule and contact family
At Children's Hospital	If there are any questions, regarding this order, please call 521-6005
	Pre-Cert Codes
	92585
Children's Hospital	92567 Precert Required?
Medical Office Building	92587
2100 Clinch Avenue	AUDIOLOGY fax to: Radiology/Sedation 541-8287 • NURSING fax to: Admitting 541-8289
Suite 410	
Knoxville, TN 37916	This paper is ready to be filed
865-521-6005	Office use only:
fax 865-521-6088	Fax Radiology/call 541-8398
COMME STORY STORY CONTRACTOR	Schedule H&P Black Book Call OR

Computer

Schedule ear check with Andy (2-5 days before SS ABR)

Schedule H&P

Children's Ear, Nose & Throat Specialists, PLLC John P. Little, M.D./ Michael Belmont, M.D. /R. Mark Ray, M.D. Children's Hospital Medical Office Building 2100 Clinch Avenue, Suite 410 Knoxville, TN 37916 865-521-6005 / 865-521-6088 (FAX)

SEDATED ABR INFORMED CONSENT

Pa	tient Name:	DOB:
Da	te of Evaluation: _	
1)	I hereby request the conditions th	and authorize Dr. Little's, Dr. Belmont's, and Dr. Ray's Audiology team to assess at appear below: Hearing loss
2)	The following protection the procedure:	rocedure(s) to be performed has been explained to me and I understand the nature of Auditory Brainstem Response (ABR)Testing under sedation and/or anesthesia at East Tennessee Children's Hospital
3)	Risks for this pro	Inability to complete study due to increased patient artifact and/or electrical interference with equipment; Inability to complete test due to technical or equipment malfunction; Inability to adequately sedate patient; Apnea (stoppage of breathing); Bradycardia (slowing of heart rate); Hypoxic Injury (too little oxygen to brain/body); Death
4)	I understand that	results are uncertain and no warranty or guarantee has been made to me.
5)	I also understand	that I will be responsible for any payment amount which insurance does not cover. ibility to ensure that insurance information is current and effective on dates of
CA BE	NCELLATION P PERMITTED TO	POLICY: A 5 DAY CANCELLATION NOTICE IS REQUIRED. YOU WILL DRESCHEDULE THIS APPOINTMENT ONE TIME.
WE BE	E REQUIRE 24 H REQUIRED IN (OURS NOTICE IF YOUR CHILD IS SICK. A DOCTOR'S EXCUSE WILL ORDER TO RESCHEDULE APPOINTMENT.
DIS	CHARGE OF PA	ATIENT MAY RESULT FROM LACK OF COMPLIANCE.
I ce	rtify that I have rea satisfactory manne	ad and fully understand this form, and that all of my questions have been answered er.
Pati Prin Date	ent (or Parent / Guated name / Relation	ardian) signature:
With Date	ness:	

ABR Summary

Children's Ear, Nose and Throat Specialists, PLLC Kristie Johnston, Au.D., CCC-A ____Emily Morgan, Au.D. Holly North, M.A., CCC-A Kristi Walden, Au.D., CCC-A Samantha Wallenstein, Au.D., CCC-A Patient Name: Chart Number: DOB: DOE: LEFT EAR RIGHT EAR **Tympanometry** OAEs (2-6kHz) CLICK (2-4kHz) dBnHL dBnHL 10dB CF corrected: dBeHL corrected:___dBeHL Absolute Latencies: Interpeak Latencies: I-III: II-V: I-V: I-V: 460 I-III:_____ III-V:____ I-V:__ ILV V: _____ <2.35 <2.35 RATE STUDY POLARITY STUDY 500Hz dBnHL dBnHL 20dB CF corrected: dBeHL corrected: dBeHL 1000Hz dBnHL dBnHL 15dB CF corrected: dBeHL corrected: dBeHL 2000Hz dBnHL dBnHL 10dB CF corrected: dBeHL corrected: dBeHL 4000Hz dBnHL dBnHL 5dB CF corrected: dBeHL corrected: dBeHL **Bone Conduction** dBnHL

dBeHL

30dB CF

(CLICK 2-4KhZ)

corrected:

corrected:

dBnHL

dBeHL

Pediatric Otolaryngology - Head and Neck Surgery, PLLC John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.



Children's Hospital Medical Office Building 2100 Clinch Avenue, Suite 410 / Knoxville, TN 37916 (865) 521-6005 • (865) 521-6088 FAX

Name Da				_ Date	ate of Evaluation					
Date of Birth				Age		Sex_		_ Char	rt Number	
125	5 2:	50 50	Freque	ncy in hertz (F		3000 40	00 6000	8000	AUDIOGRAM KEY	
10					2000	1	1	and the second participation of the		LEFT
0				-	_		1		AC UNMASKED - O	X
						1	1		AC MASKED - Δ BC UNMASKED - <	>
0									10 BC MASKED- []
0						1	-		NO RESPONSE ∠	V
-							1		THRESHOLD- THR	
						1		3	BIOLOGIC NAVIGATOR P	PRO
,			i	1	_	-	-		Insert Earphones	
						1			€ Sedated Operating F	
								5	50 € Sedated Sedation Su € Unsedated	ite
								6	MORPHOLOGY/REPEATI	BILI
-			i	+		+	1		70 € GOOD	
									€ FAIR	
								8	80 € POOR	
1				 		-	-		POLARITY STUD	Y
							1		3KhZ Click at 80dB RIGHT □WNL □ABNOR	OM AT
								1	LEFT WNL DABNOR	RMAI
						1		 ,	RATE STUDY	
-				-					3KhZ Click at 80dB 27.7 vs. 57.7	
		Correct	ed & C	orrelate	ed AB	R Th	reshoi	ds	RIGHT WNL ABNOR	MAI
	T3/3/0	PANOGRA							DEFT - WILL DABHOR	IVIAL
			Volume		21 77	GH : 17			Distortion Product Otoacoustic Emis	sions
RE	AB	C			3KHZ	Click V			(DPOAEs)	31011
E	AB	С				LEFT			RT EAR: PASS REFER History	WNL
		'							LT EAR: PASS PREFER History	WN
ESTE	DBY:_	K. Johns	ston, Au.D	"CCC-A_	н.	North, N	A.,CCC	C-A	_K. Walden, Au.DS. Wallenstein, Audiolog	ov Ex
		(to the le								
									☐ Discussed results wit	in par
	a lose los	*							Type: □CHL □SNHL	_ m
grine	g ioss ie								Type:□CHL □SNHL	
earing				tota babasi	11 0				Re-evaluate behaviorally in soundfield in	
earing	nmend Sec	ated ABR	Like-eval	uate benavio.	rally for e	ar specif	ic in	-	Re-evaluate behaviorally in soundfield in	

HEARING AID LOG SHEET

REPAIR LOG **Parent Contacted** Returned Sent for Repair Problem Date **CONTACT LOG** Type Date:

TRACKING FORM FOR HEARING AID PATIENTS Children's Hearing Center of East Tennessee

Name:			DOB:	Date of Evaluatio	n:
Audiologist:		istie Johnston, Au.D., C mily Morgan, Au.D. Sama		Walden, Au.D., CCC	
Reason child	was seen				
	ing Aid Evaluation		☐ Hearing Aid	Orientation	
	I two week follow		□ Routine Hea		
				South Control of the	
Tympanogra	ms: Right	Left Tu	bes: Right ☐ Left ☐]	
Date of Last	Audio:	Las	st Earmold Impress	ion:	
Parent Repo	rt				
HEARING AID	INFORMATION:				
	Make	Model	Serial Number		Varranty Exp.
Right:					
Left:					
	me Control: ram Buttonon P1	ON OFF OFF P2	Р3	P4	
Listening Ch					
□ Good	d Working Order	□ Concern:			
Earmolds:					
	d fit @Right ern:	Left			
Verifit:					
□ REM	S	SREMs			
□ Meas	ured RECDs	□ Avg RECDs □ R	ECDs from:		
□ Matc	th to Targets:	GoodF		r	
Software Cha	anges:				
Hearing Aid I					
□ Re-Ti		□Mic Covers/Filters	□New Tone Ho	nok	
□ Earm	old Modification	Cleaning	☐ Sent in for R		L
Return for Fo	ollow-Up:			-	
comments:_					

Children's Hearing Center of East Tennessee Verifit Measurements

Name:	
Date:	
Kristie Johnston, Au.D., CCC-A _ Holly North, M.A., CCC-A	Emily Morgan, Au.D. Kristi Walden, Au.D. CCC-A
Samantha Wallenst	



* John P. Little, M.D. Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

Michael J. Belmont, M.D. Board Certified Fellowship Trained

R. Mark Ray, M.D. Board Certified Fellowship Trained

Kristie Johnston, Au.D.
CCC-A
Holly North, M.A.
CCC-A
Kristi Waldon Au.D.

Kristi Walden, Au.D. Pediatric Audiologists

Samantha Wallenstein, M.S. Audiology Extern

> Janet L. Harris Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital Medical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916

> 865-521-6005 fax 865-521-6088

MEDICAL WAIVER

I have been advised by the professional on this document that the FDA has determined that my best interest would be served if I have a medical evaluation by a licensed physician before purchasing a hearing aid. I do not wish to obtain a medical evaluation before purchasing a hearing aid(s).

Patient	Date
Patient Signature	
Audiologist	Date
Audiologist Signature	
Audiologist Extern (if applicable)	



* John P. Little, M.D. Board Certified Fellowship Trained

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR THE COST OF SERVICES

I agree to pay the full cost of the hearing aids. I have verified that my health insurance does not cover the cost of hearing aids. I understand that Children's Ear, Nose and Throat Specialists will not file the hearing aid charges to my insurance company.

Parent/Guardian	Date	
Witness	Date	

Board Certified Fellowship Trained

Michael J. Belmont, M.D.

R. Mark Ray, M.D. Board Certified Fellowship Trained

Kristie Johnston, Au.D.
CCC-A
Holly North, M.A.
CCC-A
Kristi Walden, Au.D.

Pediatric Audiologists

Samantha Wallenstein, M.S. Audiology Extern

> Janet L. Harris Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital Medical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916



Children's Hearing Center of East Tennessee

* John P. Little, M.D. Board Certified Fellowship Trained A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Michael J. Belmont, M.D.

Board Certified Fellowship Trained

R. Mark Ray, M.D.

Board Certified Fellowship Trained

Kristie Johnston, Au.D.

CCC-A

Holly North, M.A.

CCC-A

Kristi Walden, Au.D.

Pediatric Audiologists

Samantha Wallenstein,

M.S.

Audiology Extern

Janet L. Harris

Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital Medical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916

> 865-521-6005 fax 865-521-6088

HEARING AID PRESCRIPTION

Name:		Date of Birth:		
	RI	IGHT EAR	LEFT EAR	
Manufacturer:				
Model:				
Color:				
Misc:				
Trial period: 60 for a refund min	days from time of issuus \$100.00 restocking	nance. The hearing aid(s) maybe refee per hearing aid.	eturned within this trial period	
Quote:	\$	for one hearing aid		
	\$	for one hearing aid for two hearing aids		
1. 2.	ed at No Additional Ch Hearing aid Evaluati Hearing aid Fitting Pediatric Care Kit, w	ion which includes:		
	a. Battery testb. Dehumidifi			
	c. Listening tu			
	d. Air blower			
4	e. Retention C	Clip, when applicable visits a year during the warranty p	agrical (terminally 2)	
	including:	visits a year during the warranty	beriod (typically 3 years),	
		l adjustments and programming		
		l cleanings		
I agree to pay t	c. Hearing aid	I troubleshooting and repairs ring aids. I have been informed	that my health save bonefits	
insurer may co	ver a portion of the h	earing aid costs. If Children's E the insurance company, a refun	Car, Nose, and Throat	
me.				
I also understar	id that no contractua	al insurance adjustment or disco	ount will be applied to the	
	ature:		Date:	
Audiologist:			Date:	



Children's Hearing Center of East Tennessee

* John P. Little, M.D. Board Certified Fellowship Trained

Michael J. Belmont, M.D.

A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

HEARING AID ISSUANCE FORM

			Date of Birth:	
Chart #:				
		RIGHT EAR		LEFT EAR
Manufacturer	:	RIGHT LAK		LEFT EAR
Model:				
Serial #:	_			
Battery Size:				
Color:				
Misc:				
Factory Warra	anty Expiration	Date:		
period for a re LOSS AND I	efund minus \$10 DAMAGED BE	00.00 restocking fee EYOND REPAIR -	per hearing aid. PROFESSIONAL FI	returned within this trial EE OF \$150 PER HEAR
Deriod for a re LOSS AND I AID, NOT B	efund minus <u>\$10</u> DAMAGED BE ILLABLE TO	00.00 restocking fee EYOND REPAIR – INSURANCE COM	per hearing aid. PROFESSIONAL FI MPANY	
period for a re LOSS AND I AID, NOT B Services Avai	Prind minus \$10 DAMAGED BE ILLABLE TO lable During W	00.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No	per hearing aid. PROFESSIONAL FI MPANY Additional Charge:	
Decriod for a recommendation of the LOSS AND I AID, NOT B. Services Avai	Prind minus \$10 DAMAGED BE ILLABLE TO lable During W. 1. Initial heari 2. Hearing aid	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments	
Decriod for a recommendation of the LOSS AND I AID, NOT B. Services Avai	DAMAGED BE ILLABLE TO lable During Wal. Initial heari 2. Hearing aid 3. Pediatric Ca	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments	
Decriod for a recommendation of the LOSS AND I AID, NOT B. Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari L. Hearing aid Dediatric Ca. Ba	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjuster Kit, which include the tester	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments	
period for a re LOSS AND I AID, NOT B Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari Hearing aid Pediatric Ca a. Ba b. De	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at Nong aid evaluation and programming/adjuster Kit, which include the tery tester shumidifier	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments	
Decriod for a recommendation of the LOSS AND I AID, NOT B. Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari Hearing aid Pediatric Ca a. Ba b. De c. Lis	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include tery tester chumidifier stening tube	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments	
period for a re LOSS AND I AID, NOT B Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari L. Hearing aid L. Pediatric Ca a. Ba b. De c. Lis d. Ain	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include tery tester chumidifier stening tube r blower	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des:	
period for a re LOSS AND I AID, NOT B Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari Hearing aid Pediatric Ca a. Ba b. De c. Lis d. Ain e. Re Up to ten fo	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include tery tester chumidifier stening tube r blower tention Clip, when a	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des:	
period for a re LOSS AND I AID, NOT B Services Avai	DAMAGED BE ILLABLE TO lable During W. I. Initial heari L. Hearing aid L. Pediatric Ca a. Ba b. De c. Lis d. Ain e. Re Up to ten fo including:	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include tery tester chumidifier stening tube r blower tention Clip, when a	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments les: pplicable during the warranty p	EE OF \$150 PER HEAR
period for a re LOSS AND I AID, NOT B Services Avai	Primed minus \$10 DAMAGED BETTLABLE TO Lable During W. I. Initial heariful the primed and the p	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include attery tester chumidifier stening tube r blower tention Clip, when a allow-up visits a year aring aid adjustment aring aid deleanings	PROFESSIONAL FIMPANY Additional Charge: d fitting tments des: pplicable and during the warranty prosess and programming	EE OF \$150 PER HEAR
period for a re LOSS AND I AID, NOT B Services Avai	Printed minus \$10 DAMAGED BETTLABLE TO Lable During W. L. Initial heariful and the printed search of the prin	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include attery tester chumidifier stening tube r blower tention Clip, when a allow-up visits a year aring aid adjustment aring aid deleanings aring aid troubleshoon	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des: pplicable during the warranty personal programming outing and programming	period (typically 3 years),
period for a re LOSS AND I AID, NOT B Services Avai	Primed minus \$10 DAMAGED BETTLABLE TO Ilable During W. I. Initial heariful aid B. Pediatric Canaba Banaba	20.00 restocking fee EYOND REPAIR – INSURANCE COM arranty Period at No ng aid evaluation an programming/adjus are Kit, which include attery tester chumidifier stening tube r blower tention Clip, when a allow-up visits a year aring aid adjustment aring aid deleanings aring aid troubleshoon	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des: pplicable during the warranty personal programming outing and programming	period (typically 3 years),
Deriod for a re LOSS AND I AID, NOT B Services Avai	Printed minus \$10 DAMAGED BETTLLABLE TO Itable During W. I. Initial heari 2. Hearing aid 3. Pediatric Ca a. Ba b. De c. Lis d. Ain e. Re I. Up to ten for including: a. He b. He c. He Hearing aid battlem out of reach	arranty Period at Nong aid evaluation an programming/adjuster Kit, which include the programming tube relation Clip, when a allow-up visits a year aring aid adjustment aring aid cleanings aring aid troubleshower to small children.	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des: pplicable r during the warranty per as and programming oting and repairs ous if swallowed or im	period (typically 3 years),
Deriod for a re LOSS AND I AID, NOT B Services Avai WARNING: Care to keep the	Printed minus \$10 DAMAGED BETTLLABLE TO Itable During W. I. Initial heari 2. Hearing aid 3. Pediatric Ca a. Ba b. De c. Lis d. Ain e. Re I. Up to ten for including: a. He b. He c. He Hearing aid batt them out of reach gnature:	arranty Period at No ng aid evaluation an programming/adjus are Kit, which includ attery tester chumidifier stening tube r blower tention Clip, when a allow-up visits a year aring aid adjustment aring aid deanings aring aid troubleshood arranty Period at No ng aid evaluation an programming/adjus are Kit, which includ attery tester chumidifier stening tube r blower tention Clip, when a allow-up visits a year aring aid adjustment aring aid troubleshood arranty Period at No ng aid evaluation an programming/adjus aring aid adjustment aring aid troubleshood arranty Period at No ng aid evaluation an programming/adjus are Kit, which includ attery tester aring aid adjustment aring aid adjustment aring aid troubleshood arranty Period at No ng aid evaluation an programming/adjus are Kit, which includ attery tester aring aid adjustment aring aid adjustment aring aid troubleshood arranty Period at No ng aid evaluation an programming/adjus are Kit, which includ attery tester aring aid adjustment aring aid adjustment aring aid troubleshood arranty Period at No ng aid evaluation an arr	per hearing aid. PROFESSIONAL FIMPANY Additional Charge: d fitting tments des: pplicable during the warranty personal programming outing and repairs out if swallowed or im	EE OF \$150 PER HEARI

R. Mark Ray, M.D.

Board Certified

Board Certified Fellowship Trained

Fellowship Trained

Kristie Johnston, Au.D.

CCC-A

Holly North, M.A.

CCC-A

Kristi Walden, Au.D.

Pediatric Audiologists

Samantha Wallenstein,

M.S

Audiology Extern

Janet L. Harris

Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital Medical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916



* John P. Little, M.D. Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

ADULT HEARING AID ISSUANCE FORM

ichael J. Belmont, M.D.	Name:	Date of Bi	rth:
Board Certified	Chart #:		ate:
Fellowship Trained			
R. Mark Ray, M.D. Board Certified Fellowship Trained	Manufacturer:	RIGHT EAR	LEFT EAR
	Model:		
Kristie Johnston, Au.D.	Serial #:		
CCC-A Holly North, M.A.	Battery Size:		
CCC-A	Color:		¢.
Kristi Walden, Au.D.			
Pediatric Audiologists	Misc:		
Samantha Wallenstein,	Factory Warranty Expiration	Date:	
M.S.	Trial period: 60 days from tir	me of issuance. The hearing aid(s)	maybe returned within this total
Audiology Extern	period for a refund minus \$10	0.00 restocking fee per hearing aid.	maybe returned within this trial
Janet L. Harris Office Manager		YOND REPAIR -PROFESSION	AL FEE OF \$150 PER HEARING
	Services Available During Wa	arranty Period at No Additional Cha	arge:
	Initial hearing	ng aid evaluation and fitting	
* Implant Surgeon,	2. Hearing aid	programming/adjustments er/Dry Aid Kit included in purchase	of Haning Aids
Pediatric Cochlear	4. Up to ten fo	llow-up visits a year during the war	ranty period (typically 3 years).
Implant Program At Children's Hospital	including:		
At Children's Hospital	b. He	aring aid adjustments and programs aring aid cleanings	
	c. He	aring aid troubleshooting and repair eries can be dangerous if swallowe	rs
Children's Hermited	care to keep them out of reach	of small children.	d or improperly used. Please take
Children's Hospital Medical Office Building			
2100 Clinch Avenue	Guardian's Signature:		Detail
Suite 410			Date:
Knoxville, TN 37916	Audiologist:		Date:

Hearing Aids paid in full



* John P. Little, M.D. Board Certified Fellowship Trained

Chael J. Belmont, M.D. Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

ADULT HEARING AID PRESCRIPTION

				Date of Birtil: _	
Chart #:				Today's Date: _	
Diagnosi	s/ Hear	ring Loss:			
			RIGHT EAL	2	LEFT EAR
Manufact	urer:	9 <u></u>			
Model:					
Color:					
Misc:					
Trial peri	od: 60	days from time o	f issuance. The	hearing aid(s) maybe r	returned within this trial period
for a refu	nd min	us \$100.00 restoo	king fee per he	earing aid.	
Quote:		6			
Quote:		2		for one hearing aid for two hearing aids	
		Φ		for two nearing aids	
*Custom *This que LOSS AN	earmo	ld are nonrefun alid for 30 days MAGED BEYO	dable. Custon from the date ND REPAIR-	PROFESSIONAL FE	g of hearing aid plicable \$ EE OF \$150 PER HEARING
*Custom *This que LOSS AN	earmo	ld are nonrefun alid for 30 days	dable. Custon from the date ND REPAIR-	earmold price, if app listed. PROFESSIONAL FE	plicable \$
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILI	Id are nonrefun alid for 30 days MAGED BEYO LABLE TO INS d at No Addition	dable. Custon from the date ND REPAIR- URANCE CO al Charge:	earmold price, if app listed. PROFESSIONAL FE	plicable \$
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1.	Id are nonrefun alid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva	dable. Custon from the date ND REPAIR- URANCE CO al Charge:	earmold price, if app listed. PROFESSIONAL FE	plicable \$
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILI Provide 1. 2.	Id are nonrefun alid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing	n earmold price, if app listed. PROFESSIONAL FE MPANY	olicable \$
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1. 2. 3.	Id are nonrefun alid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing ry Aid Kit incl	earmold price, if applisted. PROFESSIONAL FEMPANY	Discable \$ CE OF \$150 PER HEARING Paring Aids
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1. 2. 3.	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including:	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing yry Aid Kit included yrup visits a ye	n earmold price, if applisted. PROFESSIONAL FE MPANY uded in purchase of He ar during the warranty	olicable \$
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1. 2. 3.	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing ry Aid Kit incl y-up visits a ye	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty parts and programming	Discable \$ CE OF \$150 PER HEARING Paring Aids
*Custom *This quo LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1. 2. 3.	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing ry Aid Kit incl y-up visits a ye g aid adjustment g aid cleanings	n earmold price, if applisted. PROFESSIONAL FE MPANY uded in purchase of He ar during the warranty puts and programming	Discable \$ CE OF \$150 PER HEARING Paring Aids
*Custom *This qu LOSS AN AID, NO	earmo ote is v ND DA T BILL Provide 1. 2. 3. 4.	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing rry Aid Kit incl y-up visits a ye g aid adjustme g aid cleanings g aid troublesh	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty puts and programming ooting and repairs	EE OF \$150 PER HEARING caring Aids period (typically 3 years),
*Custom *This que LOSS AN AID, NO Services I	Provide 1. 2. 3. 4. pay that year	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin te full cost of the	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing ry Aid Kit incl y-up visits a ye g aid adjustme g aid cleanings g aid troublesh hearing aids.	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty parts and programming ooting and repairs I have been informed toosts. If Children's Females	caring Aids period (typically 3 years), that my health care benefit
*Custom *This que LOSS AN AID, NO Services I I agree to insurer m Specialist	Provide 1. 2. 3. 4. pay that year	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin te full cost of the	dable. Custon from the date ND REPAIR- URANCE CO al Charge: aluation ing ry Aid Kit incl y-up visits a ye g aid adjustme g aid cleanings g aid troublesh hearing aids.	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty parts and programming ooting and repairs I have been informed toosts. If Children's Females	EE OF \$150 PER HEARING caring Aids period (typically 3 years),
*Custom *This que LOSS AN AID, NO Services F I agree to insurer m Specialist me. I also und	Provide 1. 2. 3. 4. pay the pay the pay cover received the pay the pay the pay the pay the pay cover received the pay the pay the pay cover received the pay	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin the full cost of the er a portion of the eves a payment for	dable. Custon from the date ND REPAIR-URANCE CO al Charge: aluation ing try Aid Kit included a discounting and adjustment of a discounting and troubleshe hearing aids. The hearing aids from the insurance of the date of the	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty parts and programming ooting and repairs I have been informed I costs. If Children's Fance company, a refundance refundance in the same company, a refundance company,	caring Aids period (typically 3 years), that my health care benefit
*Custom *This que LOSS AN AID, NO Services I agree to insurer m Specialist me. I also und	Provide 1. 2. 3. 4. pay that year over received and the standard section and the standard sect	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin c. Hearin te full cost of the er a portion of the wes a payment for d that no contra	dable. Custon from the date ND REPAIR-URANCE CO al Charge: aluation ing ry Aid Kit included a discount of the date	n earmold price, if applisted. PROFESSIONAL FEMPANY uded in purchase of Hear during the warranty parts and programming ooting and repairs I have been informed a costs. If Children's Fance company, a refunce adjustment or discord	caring Aids period (typically 3 years), that my health care benefit Ear, Nose, and Throat and check will be mailed to
*Custom *This que LOSS AN AID, NO Services F Services F Specialist me. I also und cost. Guardian	Provide 1. 2. 3. 4. pay the pay the pay cover received as Signal	Id are nonrefunalid for 30 days MAGED BEYO LABLE TO INS d at No Addition Hearing aid Eva Hearing aid Fitt Dehumidifier/D Up to ten follow including: a. Hearin b. Hearin c. Hearin the full cost of the er a portion of the eves a payment for	dable. Custon from the date ND REPAIR-URANCE CO al Charge: aluation ing ry Aid Kit included a discounting and adjustments of a discounting and cleanings and troubleshe hearing aids. The hearing aids arom the insurance actual insurance actual insurance actual insurance and the date of the date	n earmold price, if applisted. PROFESSIONAL FE MPANY uded in purchase of He ar during the warranty puts and programming ooting and repairs I have been informed I costs. If Children's Euroce company, a refuncte adjustment or discontinuous control of the control	cearing Aids period (typically 3 years), that my health care benefit Ear, Nose, and Throat and check will be mailed to

R. Mark Ray, M.D. Board Certified Fellowship Trained

CCC-A

Holly North, M.A. CCC-A

Kristi Walden, Au.D.

Pediatric Audiologists

amantha Wallenstein,

M.S

Audiology Extern

Janet L. Harris Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital edical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916



* John P. Little, M.D. Board Certified Fellowship Trained

fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

NAIDA LINK HEARING AID ISSUANCE FORM

chael J. Belmont, M.D.	Name:	Date of B	irth:
Board Certified	Chart #:		Date:
Fellowship Trained			
R. Mark Ray, M.D. Board Certified	Manufacturer:	Phonak	
Fellowship Trained	Model:	Naida Link	
	Serial #:		
CCC-A	Battery Size:		
Holly North, M.A.	Color:		2
CCC-A			
Kristi Walden, Au.D.	Misc:		
Pediatric Audiologists			
	Hearing Aid Factory War	ranty Expiration Date:	
amantha Wallenstein,	Ear Mold(s) Remake Expi	nation Date:	
M.S.			
Audiology Extern	Trial period: 60 days from	time of issuance. The hearing aid m	aybe returned within this trial period
	for a refund minus \$100.00		
Janet L. Harris	Loss and Damage beyond	repair- Professional fee of \$150, not b	sillable to insurance company.
Office Manager			
	Services Available During	Warranty Period at No Additional Ch	narge:
	1. Initial ne	aring aid evaluation and fitting aid programming/adjustments	
* Implant Surgeon,	3. Pediatric	Care Kit, which includes:	
Pediatric Cochlear		Battery tester	
Control of the Contro		Dehumidifier	
Implant Program	c.	Listening tube	
At Children's Hospital		Air blower	
	e.	Retention Clip, when applicable	
	4. Up to ten	follow-up visits during the warranty	period (typically 1 year), including:
	a. h	Hearing aid adjustments and program Hearing aid cleanings	ming
Children's Hospital		Hearing aid troubleshooting and repa	ire
edical Office Building	WARNING: Hearing aid b	patteries can be dangerous if swallow	ed or improperly used. Please take
2100 Clinch Avenue	care to keep them out of re-	ach of small children.	od or improperty ased. I lease take
Suite 410			
Knoxville, TN 37916	Guardian's Signature:		Date:
865-521-6005	Audiologist:		D



* John P. Little, M.D. Board Certified Fellowship Trained

chael J. Belmont, M.D.

Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

NAIDA LINK HEARING AID PRESCRIPTION

Name:		Date of Bi	rth:
Chart #:_	×		Date:
Diagnosis/	Hearing 1	Loss:	
Manufactu		RIGHT EAR	LEFT EAR
Model:			
Color:			
Misc:		-	
Trial period for a refund	d: 60 days d minus \$1	from time of issuance. The hearing aid may 00.00 restocking fee per hearing aid.	be returned within this trial period
Quote:		\$1700 for one hearing aid	
*Warranty	y is as follote is valid to ovided at 1. Hea 2. Hea	nonrefundable. Custom earmold price, i ows: Hearing Aid 1 year; Earmold Rema for 30 days from the date listed. No Additional Charge: ring aid Evaluation ring aid Fitting	ke 30 days
	3. Ped	iatric Care Kit, which includes: a. Battery tester b. Dehumidifier c. Listening tube d. Air blower e. Retention Clip, when applicable	
	4. Up incl	to ten follow-up visits during the hearing ai uding: a. Hearing aid adjustments and programs b. Hearing aid cleanings c. Hearing aid troubleshooting and repair	ming
insurer ma Specialists me.	receives a	l cost of the hearing aid. I have been info portion of the hearing aid costs. If Child payment from the insurance company, a	ormed that my health care benefits ren's Ear, Nose, and Throat a refund check will be mailed to
I also unde cost.	rstand tha	nt no contractual insurance adjustment o	r discount will be applied to the
Guardian's	Signature:		Date:
			Date:

R. Mark Ray, M.D. Board Certified

Fellowship Trained

Kristie Johnston, Au.D. CCC-A

Holly North, M.A.

Kristi Walden, Au.D.

Pediatric Audiologists

Samantha Wallenstein,

Audiology Extern

Janet L. Harris

Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital ledical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916



Children's Hearing Center of East Tennessee

* John P. Little, M.D. Board Certified Fellowship Trained A Subdivision of Children's Ear, Nose & Throat Specialists, PLLC

Medical Clearance for Hearing Aid(s)

hael J. Belmont, M.D. Board Certified Fellowship Trained

Date of Birth:

Chart:

Patient:

R. Mark Ray, M.D. Board Certified Fellowship Trained

Cristie Johnston, Au.D.

I have evaluated the above patient and there is not a medical contraindication for him/her to receive hearing aid(s).

Comments:

Kristi Walden, Au.D. Pediatric Audiologists

Holly North, M.A.

CCC-A

amantha Wallenstein, M.S.

Audiology Extern

Janet L. Harris Office Manager

* Implant Surgeon, Pediatric Cochlear Implant Program At Children's Hospital

Children's Hospital edical Office Building 2100 Clinch Avenue Suite 410 Knoxville, TN 37916

> 865-521-6005 fax 865-521-6088

Physician

Date



Referral for Speech-Language, Feeding, Occupational and/or Physical Therapy

	Facility:		Physician Referring:
Patie	nt Name:		DOB:
Diagn	osis:		
Paren	t/Guardian Name:		Phone #:
	ces Requested:		
	Speech-Language Evaluation and Treatment		Occupational Therapy Evaluation and Treatment
	Feeding Evaluation and Treatment		Physical Therapy Evaluation and Treatment
	Augmentative Communication Device Evaluation	190	
Physic	cian Comments/Concerns:		
	cian Signature:		
Physic			
Physic	cian Signature:		Non-Oral Communication (device needed)
Physic	cian Signature: K all that apply to patient: Articulation (speech sound errors) Cleft Lip/Palate		Non-Oral Communication (device needed) Tracheotomy
Physic Check	cian Signature: K all that apply to patient: Articulation (speech sound errors) Cleft Lip/Palate Language Delay		
Physic Checl	cian Signature: K all that apply to patient: Articulation (speech sound errors) Cleft Lip/Palate		Tracheotomy
Checl	cian Signature: K all that apply to patient: Articulation (speech sound errors) Cleft Lip/Palate Language Delay		Tracheotomy Tube Fed

Please send any relevant patient information (including insurance information and preferred contact information for patient) needed for referral. Our office will take care of verifying insurance coverage and benefits and will contact the family to schedule appointments. A copy of the evaluation will be sent to your office upon completion and progress notes may be sent at the request of the referring provider.



Hearing and Speech Center (UTK Campus) 1600 Peyton Manning Pass

Knoxville, TN 37996-2500 Phone: 865-974-5451

FAX: 865-974-4639

NEW PATIENT REFERRAL FORM - SPEECH-LANGUAGE

PATIENT INFORMATION				7 2 11 7 2 11 7 2 1 1 1 1 1 1 1 1 1 1 1	Revised 11/2016
Patient Name:				DOB:	Male/Female
Parent/Spouse/Guardian:					
Address:			City:	State:	Zip:
Home Phone:		Cell Phone:		Work Phone:	
PURPOSE OF REFERRAL AREAS OF CONCERN (chee	[] Treatment	uding a hearing evaluation	n, if indicated)	PLEASE NOTE: This referral is effective date a properly completed a received. Our center will send referrals annually on establi	and signed form is equests to update
72.0		Fraumatic Brain Injury	[] Fluency	[] Apraxia [] Autism	
[] Language [] V					
				Fiberoptic Endoscopic Evaluation of S	
PROVIDER INFORMATION					
Referring Physician:			→ Before	we can achedule your nations and	Lill for in control
Address:			_ must h	we can schedule your patient and ave the referring provider's NPI.	bill for insurance we
Phone #:	Fax #:		-	also sand all relevant modical aut	
Provider's NPI:			Please	also send <u>all</u> relevant medical note	es or test results
Primary Care Provider:					
Phone #:				nt currently receiving home healtho	care services?
Provider's NPI:			- INO IN	es List Provider	
INSURANCE INFORMATION			101-01-		
Primary Carrier:					
Subscriber ID#:	Gro	oup #:		AND	
Secondary Carrier:				74115	
Subscriber ID#:	Gro	up #:	> Send a	copy of the patient's insurance car	rd/s (front and back)
Is a pre-cert or authorization					
Authorization/pre-cert #:					
Dates visits are valid:					
Referring Provider's Signatur	e (Required):			Dat	A:

THE UNIVERSITY of TENNESSEE UT HEALTH SCIENCE CENTER

Department of Audiology and Speech Pathology

Referring Provider's Signature (required for patients 21 years and under):

Audiology Clinic (UTK Campus) 455 South Stadium Hall Knoxville, TN 37996-0740 Phone: 865-974-5453

Date:

FAX: 865-974-1792

PATIENT INFORMATION	NEW PATIENT REFERR	RAL FORM - AUDIOLOGY	Revised 4/2017
Patient Name:		DOB:	Male/Female
Parent/Spouse/Guardian:			•
Address:		City:	State:Zip:
, , , , , , , , , , , , , , , , , , , ,		Work Phone: _	
CHIEF COMPLAINT and/or DIAGNOSIS (i	i.e. hearing loss, tinnitus, dizziness)		
List all that apply including associa	ated ICD-10 Code(s):		
MEDICAL CLEARANCE: Is there any	y medical basis to contraindicate the us	se of hearing aids if the patient meets of	candidacy?YesNo
PURPOSE OF REFERRAL: (Check all app			
indicated) [] Amplification Evaluation [] Auditory Processing Evaluation - [] Dizziness Clinic Evaluation [] Tinnitus Evaluation (including a H [] Unilateral Hearing Loss Evaluation [] Neurological Auditory Brainstem Re: [] Threshold Auditory Brainstem Re: [] Electrocochleography (ECochG) [] Cochlear Implant Programming [] Cochlear Implant Assessment (Pre [] Aural Oral Evaluation/Speech-Land	Age 7 & Older (including a speech-lang dearing Evaluation, if indicated) on (including spatial hearing evaluation) Response Evaluation (ABR) esponse Evaluation (ABR) and/or Pediate/Post) including Dizziness Clinic Evaluation	guage evaluation, if indicated) atric Hearing Evaluation uation Date of CL surgery:	PLEASE NOTE: This referral is effective for one year from the date received. Our Center will send requests to update referrals on established patients.
PROVIDER INFORMATION		, e	
Referring Physician:		- > Before we can schedule voi	
Address:		_ I must have the referring prov	ur patient and bill for insurance we vider's NPI.
Phone #:	Fax#:		
Provider's NPI:		> Please also send <u>all</u> relevan	t medical notes or test results
Primary Care Provider:			
Phone #:		Is this patient currently receiving	n home healthcare services?
Described - NIDI		_ []No []Yes List provider	
NSURANCE INFORMATION			
Insurance Carrier:			
Medicare? Yes/No Supplemental	2 Yes/No TennCare? Yes/No		AND
			AND
Subscriber ID#:			1
s a pre-cert or authorization number			s insurance card (front and back)
Authorization/pre-cert #:	# of visits:		



In TEIDS: Cc: ______ Initial Referral Form County: ____ Phone: 865-579-3099; Fax: 865-579-5033 SC: ______ Rev. 3/19/14 ID#:

OFFICE USE ONLY

Gender: male female SSN:
ck Hispanic White Language other than English:
Zip: County:
Agency Name:
FAX:
Group Name:
FAX:
er Kinship
Phone:
Phone:

NOTES:

TRACKING FORM FOR COCHLEAR IMPLANT PATIENTS—BEHAVIORAL EVALUATION ONLY Children's Hearing Center of East Tennessee

Name		DOB:	Date of Evaluation
Audiologist:	Kristie Johnston, Au.D., CCC-A Emily Morgan, Au.D.	Holly North, N Kristi Walden Samantha Wa	
Reason child was seen	Processor/Serial Nu	mber (s) Upon Arrival:	
☐ Concern of patient/Pa☐ New or replacement of Routine visit		tings R	L Settings
Start Time:			
End Time:			
Parent Report	X 1/1	i	
Therapy	Tracki		Dr. Little
STATUS UPON ARRIVAL: Magnet strength: Discussed observation	10.	W,	
Ear and head check: No Concern Concern:			relling, irritation, etc.
Equipment check: Good working condi			
☐ Request insurance r	eimburse		
Impedances: ☐ All values were acce ☐ The following electron ☐ The following electron	odes disprayed odes were deactivated		
Evaluation:			
☐ Audio acceptable but	ight Left d for follow-up mapping Right ut patient indicates desire for program	ming changes Right	Left
Tympanograms: Right			
Return for follow-up			

TRACKING FORM FOR COCHLEAR IMPLANT PATIENTS—MAPPING APPOINTMENT Children's Hearing Center of East Tennessee

Name_						DO	DB:		Da	ate of Eval	uatio	n	
Audiolo		Em	istie Johnstor illy Morgan, A	n, Au.D., CCC- Au.D.	-A	Hol	ly Norti	n, M.A., en, Au.	CCC-A				
		vas seen							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		Stimulation		Pro	cessor(s) st	atus upon arı	rival:						
		rn of patient/P		Diel	h.								
		r replacement	device fitting	Kigi	nt:	Setting:	5 <u>P</u>	Ma	p#	Serial #			
	Routin	ne visit											
				Leit		Setting	S P	Ma	p#	Serial #			
arent F	Report											All Sections	
										Y. (1)			
								Last Se	en by Dr. L	.ittle			
TATIL	SUPO	N ARRIVAL:											
		A CONTRACTOR OF THE PARTY OF TH											
lagnet:	strengt	th:											
	Discus	sed observation	on of skin be	neath the si	te of the co	il placement	for rec	ness, s	welling irrit	tation etc			
								, ,	0) !!!!!		••		
ar and I		T. TOTAL CO.											
	No Co												
	Conce	rn:											
				FILE MES			- Company				_		
quipme	ent che	ck:											
	Good	working condi	tion										
	Reque	st RMA for											
	Poque	st RMA for st insurance re											
	neque	st insurance re	elmburseme	nt for									
ROGR			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1										
npedan		ING											
	All valu	ues were acce	otable										
	The fol	llowing electro	des displaye	ed abnormal	values								
	The fol	llowing electro	des were de	eactivated						Samuel Services			
RT:													
mpano	ograms:	: Right	Left									HAVE TO STATE OF	
	0		Leit_										
TATUS	AT DE	PARTURE-	MAD NIIMAD	EDC 9. Cr									
iman, E	2-0-0-0		IVIAP IVUIVIB	EKS & SEIII	NGS								
illal y r	rocess	or/Serial Nun	iber (s):			Bac	kup Pr	ocessor	/Serial Nur	nber (s):		Dir	NOT BRING
_										(-).			NOI DRING
R	L	Settings	R	L Set	ttings		R	L	Settings	_	-		
			P1_			D1	100000	-	Settings		R	L	Settings
			P2_							_ P1			
						P2				_ P2			
			P3			P3				_ P3			
			P4_						A THE PARTY OF THE				
			The second second second second			P4 _				_ P4			
1			P5			P5_				_ P5			
	r follow	-tip											
	follow	-up											
turn for		-up						VIII VIII - TILL	The state of the s				
turn for		-up						A.Viewoji					
turn for		-up											
turn for		-up											
turn for		-up											
turn for	s												
turn for	s	-up				ind Time:							
eturn for		-up											

TRACKING FORMS FOR BAHA PATIENTS Children's Hearing Center for East Tennessee

Name:	D	OB: Date	e of Evaluation:	
	Kristie Johnston, Au.D., CCC-A		rth, M.A., CCC-A	•
	Emily Morgan, Au.D.	Kristi Wa	alden, Au.D., CCC-A	
		Samanth	na Wallenstein, Au.D., CCC-A	
		Last seen by physician:		
REASON CHILD WAS SEEN		Last seen by physician		
☐ Initial Fitting		Start Time:	End Time:	
☐ Routine visit				
☐ Concern of pati	ent/parent/teach/audiologist/the	erapist		
☐ New or replace	ment device fitting programs placed on replacement	4-1-1		
_ oma not seen,	programs placed on replacement	device only		
PARENT REPORT:				
			/	
STATUS UPON ARRIVAL				
Device:				
□ Softband				
□ Implant				
Processor(s): Right:	Program:	S/#:	Color:	
Lert: _	Program:	S/#:	Color:	
Ear and Head Check: No Concern				
☐ Concern:				
				_
Equipment Check:				
Good working co	ondition			
Request RMA for	with:			_
				_
The second secon	ce Reimbursement:			
	oc			_
valuation:				-
□ Audio acceptable	e			
Audio indicates :	need for follow up programming			_
TATUS AT DEPARTURE				
rimary Processor(s):	1-6-6/4	Backup Processor(s):		
tight S/#:			Left S/#:	
olor:			Color:	
1:		P1:	P1:	
2:			P2:	
3:	P3:	P3:	P3:	
ETURN FOR FOLLOW-UP:				P()
				_
COMMENTS:				

Pediatric Otolaryngology - Head and Neck Surgery, PLLC John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.



Children's Hospital Medical Office Building 2100 Clinch Avenue, Suite 410 / Knoxville, TN 37916 (865) 521-6005 • (865) 521-6088 FAX

Name			logress Note	
			Date of Evaluation	
eate of Birth	Age	Sex	Chart Number	
istory:				
			Committee of Action 1999 The Action 1999	
	1			
idiological findings:				191
idiological findings:				
e				
				-
	1 .			
				× .
n:				¥2
				4.
		, e		



* John P. Little, M.D. Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

NEWBORN HEARING EVALUATION

hael J. Belmont, M.D.	Name:		DOB:		Date:
Board Certified Fellowship Trained	HISTORY:				
renowship framed		at Disth			
	Weeks Gestation	at Birth:			
R. Mark Ray, M.D. Board Certified	NICU Stay/Risk	Factors:			
Fellowship Trained	Normal Pregana Complica		NO		
ristie Johnston, Au.D.	Family History o	f Hearing Loss: YES	NO		
CCC-A			VIII 0		
Holly North, M.A.	IF YES:	rn Hearing Screening: At:	YES	NO	
CCC-A Kristi Walden, Au.D.		Obtained by:	DPOAEs	ALGO	ABR
Pediatric Audiologists		Abnormal responses	at the: Righ	t Ear Le	ft Ear
Audiology Extern	Distortion Prod	uct Otoacoustic Emis	sions (DPOAEs)	Right: Pas Left: Pas	
Audiology Extern Janet L. Harris Office Manager	Auditory Brains	stem Response (ABR)	:	Left: Pas	s Refer
Janet L. Harris Office Manager	Auditory Brains	stem Response (ABR)	:	Left: Pas	s Refer
Janet L. Harris Office Manager *Implant Surgeon,	Auditory Brains Right: Left:	stem Response (ABR)	:	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear	Auditory Brain: Right: Left: RECOMMENDA Refer back	Stem Response (ABR) FIONS: to pediatrician for media	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program	Auditory Brain: Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate	FIONS: to pediatrician for medicadiatric Otolaryngology hearing following medical	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program	Auditory Brain: Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate	FIONS: to pediatrician for medicalizatric Otolaryngology	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program Children's Hospital	Auditory Brains Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate Reevaluate	FIONS: to pediatrician for medicadiatric Otolaryngology hearing following medical	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program Children's Hospital Children's Hospital ical Office Building	Auditory Brains Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate Reevaluate	FIONS: to pediatrician for medicadiatric Otolaryngology hearing following medical	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program t Children's Hospital Children's Hospital lical Office Building	Auditory Brains Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate Reevaluate	FIONS: to pediatrician for medicadiatric Otolaryngology hearing following medical	cal management	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program t Children's Hospital dical Office Building 2100 Clinch Avenue Suite 410	Auditory Brains Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate Reevaluate Comments:	FIONS: to pediatrician for medical distriction of the control of t	cal management referral cal management in	Left: Pas	s Refer
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program t Children's Hospital Children's Hospital dical Office Building 2100 Clinch Avenue	Auditory Brains Right: Left: RECOMMENDA Refer back Consider Pe Reevaluate Reevaluate Comments: Thank you for this	FIONS: to pediatrician for medical diatric Otolaryngology hearing following medical hearing in soundfield in referral! It was a pleas	cal management referral cal management in	Left: Pas	thcare of your patients
Janet L. Harris Office Manager * Implant Surgeon, Pediatric Cochlear Implant Program t Children's Hospital Children's Hospital dical Office Building 2100 Clinch Avenue Suite 410	Auditory Brains Right: Left: Refer backConsider PeriodReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluateReevaluate	FIONS: to pediatrician for medical diatric Otolaryngology hearing following medical hearing in soundfield in referral! It was a pleas	cal management referral cal management in	Left: Pas	thcare of your patients. Holly North, M.A., CCC-A



* John P. Little, M.D. Board Certified Fellowship Trained Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

HEARING EVALUATION

	Name:DOB:Date:	
ichael J. Belmont, M.D.	History:	
Board Certified		
Fellowship Trained		
R. Mark Ray, M.D.		
Board Certified		
Fellowship Trained	Otoscopy: Right: unremarkable Comment: Left: unremarkable Comment:	
Kristie Johnston, Au.D. CCC-A Holly North, M.A.	Left: Type Pressure Volume	
CCC-A Kristi Walden, Au.D. Pediatric Audiologists	Distortion Product Otoacoustic Emissions (DPOAEs): Right: Pass Refer Comments: Left: Pass Refer	
Samantha Wallenstein,	Speech Reception/Awareness Thresholds: RightdB LeftdB Sound fieldd	В
M.S.		
Audiology Extern	Word Recognition Scores: Right% atdB Left% atd	В
-0,	Behavioral Evaluation:Visual Reinforcement Audiometry (VRA)	
Janet L. Harris	(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
Office Manager		
	Results: Hearing WNL:RightLeftSound field (for at least one ear)	
	Hearing Loss Sound field:	
* Implant Surgeon,	Hearing Loss Right:	
Pediatric Cochlear	Hearing Loss Left:	
Implant Program		
At Children's Hospital	Recommendations:	
· · · · · · · · · · · · · · · · · · ·	Refer back to pediatrician for medical management	
	Consider Pediatric Otolaryngology evaluation	
	Reevaluate hearing following medical management in Reevaluate hearing in	
Children's Hospital		
edical Office Building	Reevaluate hearing at 3 years of age (when ear specific thresholds can be obtained) No further audiological follow up is necessary	
2100 Clinch Avenue		
Suite 410	Comments:	
Knoxville, TN 37916		
865-521-6005		
003 321-0003		

Drs. Little, Belmont and Ray
Kristie Johnston, Au.D., CCC-A//Emily Morgan, Au.D.//Holly North, M.A., CCC-A
K. Walden, Au.D., CCC-A//S. Wallenstein, Au.D., CCC-A
865-521-6005//(f)865-521-6088

PATIENT NAME:	CHART#:
---------------	---------

RIGHT

Date	Tymp	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
									en.		
					doctor and the						
											9000

LEFT

Date	Tymp	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
											and the second
									tronger or and		
		-0									
									E F		
											-

Children's Ear, Nose & Throat Specialists John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

East Office

Children's Hospital Medical Office Building 2100 Clinch Avenue, Suite 410 / Knoxville, TN 37916 (865) 521-6088 FAX

West Office

9546 S. Northshore Drive Knoxville, TN 37922 (865) 415-3430

PHONE: (865) 521-6005

AUDIOLOGICAL EVALUATION

)ate	of Birth				Age		Sev		Chart No	mber		
Juic	or Dirtin				_ Age_		Sex		_ Chart No	imber		
1	25 1	50	500		cy in hertz	(Hz) 0 2000	3000 400	00 6000	8000		AUDIOGRA	AM KEY
											AC UNMASKED -	o x
0					:				0			Δ □ < >
			30								BC MASKED-	Ĺĺ
0									10		NO RESPONSE	k y
0	100000					5323					NO RESTONSE	
			CRESS PROPERTY.						20		SOUND FIELD - THRESHOLD-	* THR or θ
)				-	+ +		+	-	30			
								:			AUDIOM CALIBRATED TO A	
0									40		GSI	
											East Office	☐ West Office
)	0.75								50		□ Booth A	□ Booth B
				+	-	1	-		60		RELIABILITY	METHOD
				1					00		GOOD	□VRA
				+	+ +		-		70		FAIR	□CPA
											□POOR	□BOA
)								1	80		COULD NOT CO	ONDITION
				i							☐ SCARED OF VR	A
)									90		☐ DID NOT TEST	<15dB
,				-	1		-		100		□ FATIGUED	
									100		☐ COULD NOT TE	ST MASKED BC
)									110		PURE TONE . (500, 1000 &	
0									120		Air RtdB	LtdB
RE LE	TYM A B A B	PANOGE	Sert earp		SPEEC (live voice) RT EA	R	Reception AwarenessdB_LT_E	AR	ESHOLD	RT EAR	PRD RECOGNITIO	MCL UC _dB dBdB dB
							d Field				Stimuli	
											lden, Au.DS. V	
eari	ng WNL:	□right L	⊥left L	sound	lfield (for	at least on	e ear) Hear	ing loss	soundfield:_		950-21	
											Type: □CHL	
											Type: □CHL [
							Pass				Es R/L □Recomm	
Disc	cussed resu	ilts with t	parents	□ Co	unseled n	arents o	n practicin	g CPA	History A	BR WNL R/L	☐ Stable Hearing	R/I. Dev D
							The second second	The same of the sa			lear to complete I	