

SHF ID #:

Phase 1 & 2 Patient Form

Write using "BLOCK" letters. Fill in circles completely →
 For mistake, cross-out mistake, then the correct answer



1. PHASE 1 - REGISTRATION		completed by:
Phase 1 Date: <input type="text"/> / <input type="text"/> / <input type="text"/> DD MM YYYY		Phase 1 City: _____
Surname: _____		
First Name: _____		
Region/District: _____		
City/Village: _____		
Gender: <input type="radio"/> Male <input type="radio"/> Female	DOB: <input type="text"/> / <input type="text"/> / <input type="text"/> DD MM YYYY	Age: _____
Mobile Number: <input type="radio"/> SMS		
Alternative Number: <input type="radio"/> SMS		
1. Do you have a hearing loss? (1) <input type="radio"/> No (2) <input type="radio"/> Undecided (3) <input type="radio"/> Yes 2. Do you use sign language? (1) <input type="radio"/> No (2) <input type="radio"/> A little (3) <input type="radio"/> Yes 3. Do you use speech? (1) <input type="radio"/> No (2) <input type="radio"/> A little (3) <input type="radio"/> Yes		
4. Hearing Loss Cause: <input type="radio"/> Medication <input type="radio"/> Meningitis <input type="radio"/> Aging <input type="radio"/> Ear Infection <input type="radio"/> HIV <input type="radio"/> Tuberculosis <input type="radio"/> Malaria <input type="radio"/> Trauma <input type="radio"/> Birth <input type="radio"/> Other <input type="radio"/> Unknown		
5. Do you experience a ringing sensation in your ear? (1) <input type="radio"/> No (2) <input type="radio"/> Undecided (3) <input type="radio"/> Yes 6. Do you have pain in your ear? (1) <input type="radio"/> No (2) <input type="radio"/> A little (3) <input type="radio"/> Yes		
(FOR PATIENTS 18 & OLDER) 7. How satisfied are you with your hearing? (1) <input type="radio"/> Unsatisfied (2) <input type="radio"/> Undecided (3) <input type="radio"/> Satisfied 8. Do you ask people to repeat themselves or speak louder in conversation? (1) <input type="radio"/> No (2) <input type="radio"/> Sometimes (3) <input type="radio"/> Yes		
Employment Status: (1) <input type="radio"/> Employed (2) <input type="radio"/> Self Employed (3) <input type="radio"/> Not Employed		
Highest Level of Education Attained: <input type="radio"/> None <input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Post Secondary		
CURRENT STUDENT <input type="radio"/> Yes	School Name: _____	
	School Phone Number: _____	
2A. EAR SCREENING		completed by:
Ears Clear for Impressions (IF YES, SKIP TO SECTION 3): <input type="radio"/> No <input type="radio"/> Yes		
2B. OTOSCOPY		completed by:
LEFT RIGHT Wax <input type="radio"/> <input type="radio"/> Infection <input type="radio"/> <input type="radio"/> Perforation .. <input type="radio"/> <input type="radio"/> Tinnitus <input type="radio"/> <input type="radio"/> Atresia <input type="radio"/> <input type="radio"/> Implant <input type="radio"/> <input type="radio"/> Other <input type="radio"/> <input type="radio"/>		Medical Recommendation: <input type="radio"/> Left <input type="radio"/> Right Medication Given: <input type="radio"/> Antibiotic <input type="radio"/> Analgesic <input type="radio"/> Antiseptic <input type="radio"/> Antifungal Ears Clear for Impressions: LEFT <input type="radio"/> No <input type="radio"/> Yes RIGHT <input type="radio"/> No <input type="radio"/> Yes Comments: _____
3. HEARING SCREENING		completed by:
Screening Method: <input type="radio"/> Audiogram <input type="radio"/> WFA® Voice Test		
Left Ear: <input type="radio"/> Pass <input type="radio"/> Fail	Right Ear: <input type="radio"/> Pass <input type="radio"/> Fail	
IF PATIENT (18 & OLDER) PASSES: How satisfied are you with your hearing? <input type="radio"/> Unsatisfied <input type="radio"/> Undecided <input type="radio"/> Satisfied		
4. EAR IMPRESSIONS		completed by:
Ear Impressions: <input type="radio"/> Left <input type="radio"/> Right		
Comments: _____		
5. FINAL QUALITY CONTROL		completed by:
<input type="radio"/> Ear impressions inspected & collected <input type="radio"/> SHF ID number and ID card given		

1. PHASE 2 - REGISTRATION		completed by:		
Phase 2 Date: <input type="text"/> / <input type="text"/> / <input type="text"/> DD MM YYYY		Phase 2 City: _____		
Patient Type: <input type="radio"/> Registered Phase 1 <input type="radio"/> No Earmolds <input type="radio"/> Walk-in				
2A. EAR SCREENING		completed by:		
Ears Clear for Fitting (If yes, skip to section 4A): <input type="radio"/> No <input type="radio"/> Yes				
2B. OTOSCOPY		completed by:		
LEFT RIGHT Wax <input type="radio"/> <input type="radio"/> Infection <input type="radio"/> <input type="radio"/> Perforation.. <input type="radio"/> <input type="radio"/> Tinnitus..... <input type="radio"/> <input type="radio"/> Atresia..... <input type="radio"/> <input type="radio"/> Implant..... <input type="radio"/> <input type="radio"/> Other..... <input type="radio"/> <input type="radio"/>		Medical Recommendation: <input type="radio"/> Left <input type="radio"/> Right Medication Given: <input type="radio"/> Antibiotic <input type="radio"/> Analgesic <input type="radio"/> Antiseptic <input type="radio"/> Antifungal Ears Clear for Fitting: LEFT <input type="radio"/> No <input type="radio"/> Yes RIGHT <input type="radio"/> No <input type="radio"/> Yes Comments: _____		
3. HEARING SCREENING		completed by:		
Screening Method (ONLY for Walk-in patients): <input type="radio"/> Audiogram <input type="radio"/> WFA® Voice Test				
Left Ear: <input type="radio"/> Pass <input type="radio"/> Fail	Right Ear: <input type="radio"/> Pass <input type="radio"/> Fail			
IF PATIENT (18 & OLDER) PASSES: How satisfied are you with your hearing? <input type="radio"/> Unsatisfied <input type="radio"/> Undecided <input type="radio"/> Satisfied				
4A. HEARING AID FITTING		fitter name:		
RESULTS	POWER LEVEL	VOLUME	BATTERY	EARMOLD
LEFT EAR			<input type="radio"/> 13 <input type="radio"/> 675	
RIGHT EAR			<input type="radio"/> 13 <input type="radio"/> 675	
Number of Hearing Aids Fit: <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 Normal Hearing..... <input type="radio"/> <input type="radio"/> Distortion..... <input type="radio"/> <input type="radio"/> Special Device: <input type="radio"/> Bone Conductor (675 battery) <input type="radio"/> Body Aid (AA battery) If patient received 1 or 0 hearing aids, select option to the right: <input type="radio"/> Recruitment <input type="radio"/> <input type="radio"/> <input type="radio"/> No Response <input type="radio"/> <input type="radio"/> <input type="radio"/> Other <input type="radio"/> <input type="radio"/>				
Comments: _____				
4B. FITTING QUALITY CONTROL		completed by:		
Patient Clear for Counseling: <input type="radio"/> No <input type="radio"/> Yes				
5. COUNSELING		completed by:		
<input type="radio"/> Patient completed counseling and received AfterCare information <input type="radio"/> Patient has been trained as a Student Ambassador				
6. FINAL QUALITY CONTROL		completed by:		
Number of batteries provided: 13 _____ 675 _____				
(For patients 18 & older) When wearing your hearing aid(s) are you satisfied with your hearing? (1) <input type="radio"/> No (2) <input type="radio"/> Undecided (3) <input type="radio"/> Yes				
Patient Signature (Parent/Guardian if younger than 18 years old): X				
Comments: _____				

Waiver & Release of Liability

Signature is REQUIRED to receive services

In exchange for the services rendered and any hearing aid(s) provided to me, at no charge, by **Starkey Hearing Foundation LLC** (the "Foundation"), located at 6700 Washington Avenue South, Eden Prairie, Minnesota 55344, United States of America, I **knowingly and voluntarily confirm the following:**

1. Otoscopy and Ear Mold Procedures. I give permission for examination of my ears by otoscope. If I qualify for hearing aids under the Foundation's program, I give permission for molds to be made of my ears, to make hearing aids. I understand that there are risks in both examination and molding. Superficial bleeding or minor pain may occur when ear wax is removed and the otoscope is used. If I qualify for a hearing aid, trained Foundation volunteers will insert Otoform or another industry-standard putty into my ear canals to make custom ear molds. There is a slight risk that some of the putty may become lodged in my ear canal, requiring removal by surgical procedure.

2. Waiver and Release. I hereby release and forever discharge and hold harmless the Foundation and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise in connection with my participation in the examination, otoscopy, and ear mold Procedures. I recognize that this WAIVER AND RELEASE OF LIABILITY discharges the Foundation from all liability and claims I may have against the Foundation regarding any bodily or personal injury that may result or arise from the otoscopy, ear mold, and related procedures, whether caused by the negligence of the Foundation or its officers, directors, employees, agents, or volunteers, or otherwise.

3. Applicable Law. I expressly agree that this WAIVER AND RELEASE OF LIABILITY is governed and interpreted by the laws of the country in which I receive the examination and mold procedures and is intended to be as broad and inclusive as permitted by those laws. I further agree that if a court determines any portion of this WAIVER AND RELEASE OF LIABILITY to be invalid, that determination shall not affect the rest of this WAIVER AND RELEASE OF LIABILITY, which shall remain enforceable.

4. No Duress and Language. I agree and acknowledge that I am under no pressure or duress to sign this WAIVER AND RELEASE OF LIABILITY and I have been given reasonable opportunity to review it before signing. I acknowledge that this WAIVER AND RELEASE OF LIABILITY has been read to me in a language I understand and a copy of it has been given to me if I requested it. I understand that I may at any time decline the otoscopy and ear mold procedures and any other Foundation services and procedures, but then the Foundation will not be able to provide the hearing aid(s).

I have thoroughly read this document and understand its contents. I further understand that by signing this WAIVER AND RELEASE OF LIABILITY, I voluntarily surrender my legal rights, as indicated above.

Media Release

Patient declined to sign Media Release

Signature is NOT required to receive services



I know that I do not need to sign this Media Release in order to receive hearing device(s) or participate in a mission event, and I have the right to stop the recording and photography at any time. I **hereby grant permission** to Starkey Hearing Foundation (the "Foundation") and its employees, licensees, and agents, **to take, record, use, and reproduce, for any legal purpose, the name, likeness, image, and voice, on film, audio or video tape, digital recording, or other recording media, of me and of the minor child named below (the "Child")**, in connection with all initiatives, activities, or events of the Starkey Hearing Foundation in the country in which I am signing this Release (the "Initiatives"). I represent and warrant that I have the authority to enter into this Release on behalf of myself and the Child, and that this Release is not and will not be in conflict with any commitment, agreement, or understanding with any other person or entity and will not infringe the rights of any person or entity. On behalf of myself, the Child, and our heirs, representatives, and administrators, and any other person acting on behalf of the estate of the Child or me, I hereby:

1. authorize the Foundation and its employees, licensees, and agents to copyright, publish, reproduce, exhibit, transmit, broadcast, televise, digitize, display, and otherwise use and permit others to use my and the Child's name, image, likeness, and voice; and to use all recordings, videotapes, audiovisual materials, writings, statements, quotations, and photographs of the Child and me (collectively, the "Materials"), in any manner, form or format now or hereafter created, including without limitation any physical, digital, or electronic uses; throughout the world for the purposes of advertising and/or promoting the Foundation, including but not limited to its activities, programs, and mission.

2. acknowledge that all of the Materials, and all copies thereof, are the sole property of the Foundation, and agree to not contest the rights or authority that are granted hereunder; and hereby waive any and all rights to inspect or approve the finished images, photographs, or electronic matter prior to publication whether used now or in the future, and whether that use is known or unknown to me; and hereby waive any right to royalties or other compensation arising from or related to the taking, recording, using, publishing, and reproducing of the Materials.

3. forever release and discharge the Foundation, and its employees, licensees, and agents, including any publisher or distributor, from any claims, actions, damages, liabilities, costs, or demands whatsoever arising out of or in connection with the use of the Materials, including but not limited to any claims for defamation, invasion of privacy, right of publicity, right of confidentiality, copyright infringement, or any other personal or property or "moral" rights claims arising from or related to any use of any of the Materials in whole or in part.

4. understand that the Materials or any part of them could constitute protected health information ("PHI"), and that once published or re-disclosed in any form, the Materials will continue to be used and will not be protected by regulations protecting privacy of an individual's PHI under the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") and other applicable U.S. laws. Regarding PHI, this Release may be revoked by notice in writing to the Foundation at the address listed below, specifying "Attention: Office of the General Counsel." Such a revocation will apply only to versions of the Materials within the Foundation's control that have not been previously published or disclosed. Unless revoked in this way, this Release will exist for twenty (20) years as to PHI and perpetually for non-PHI. I may inspect or copy the published or disclosed PHI by sending a request in writing to the address listed above in this paragraph.

I have thoroughly read this document and understand its contents, and I have been free to present in writing any questions I have before signing. Failure to ask any questions means that I accept it fully. I further understand that by signing it I voluntarily surrender my and the Child's legal rights, as indicated above. I acknowledge that this Release has been read to me in a language I understand and that I have received a copy of this Release if I have requested it.

Patient Name (Print)

Patient Signature Date (DD / MM / YYYY)

If the person receiving the procedures is a minor according to the applicable law above, the adult signing below represents that he or she has full authority to act on behalf of the minor, without conflicts of interest, and that the adult has read and understands this WAIVER AND RELEASE OF LIABILITY and approves and accepts it on behalf of the named minor.

Parent or Guardian (Print) If patient is under 18

Signature of Parent/Guardian Relation to Minor

Patient Name (Print)

Patient Signature Date (DD / MM / YYYY)

Parent or Guardian (Print) If patient is under 18

Signature of Parent/Guardian Relation to Minor