Medical Clearance Form for Hearing Test

Patient Name: _____ **Phone Number:** (____) _____

Address:

_____

_____

It is in your best health interest to have a medical evaluation by a physician. This medical clearance form is required for individuals who have or suspect any of the following conditions:

- Visible congenital or traumatic deformity of the ear
- Current ear infection
- History of active drainage from the ear within the past 90 days
- Sudden or rapid progression of hearing loss within the past 90 days in one or both ears
- Acute or chronic dizziness
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
- Pain or discomfort in the ear
- Individuals with poor dexterity, poor vision, or significant dementia
- Fluctuating hearing sensitivity
- Sudden onset or rapid worsening of tinnitus within the past 90 days
- History of conductive or mixed hearing loss or ear surgery

To be completed by a Physician

The following information relates to _____, a patient in my care.
Patient Name

I evaluated this patient's health within the last three months. This patient may be considered a candidate for a hearing test.

_____ _____
Physician's Signature *Date*

_____
Phone

Fax: (510) 276-4437 **e-mail:** audiology@ihearmedical.com **Mail:** **Audiology, iHear Medical, Inc.**
15250 Hesperian Blvd. Suite 102
San Leandro, CA 94578