Hear at Home LTD.®
MOBILE HEARING CLINIC

Hear at Home c/o Canopy Integrated Health
149-1233 Lynn Valley Road,
North Vancouver, BC V7J 0A1
778-340-1101

Consent for a Hearing Assessment

PATIENT INFORMATION

☐ MALE ☐ FEMALE

Name of Patient: _____

Date of Birth (m/d/y): _____

Family Physician: _____ Phone #: _____

Name of Care Home: _____ Room #: _____

Date of last hearing assessment: _____

Patient Currently Wears Hearing Aids: ☐ No ☐ Yes

DVA (K number): _____

Please indicate hearing difficulties: _____

_____

Person to call with exam results: _____

Phone#: _____ Email: _____

Relationship to the Patient: _____

FEE SCHEDULE:

Home Visit/Audiological Hearing Exam: _____

NOTE:

Ambient noise must be below 45dBa in the testing environment. If the noise level exceeds this, an alternate location may be used.

If the ear(s) are blocked with wax the patient will have to have the wax removed before a test can be administere d.

By Signing Below, I confirm that I have read & completed the information in full & confirm the information provided is accurate to the best of my knowledge. I also agree to pay the fee as outlined in the fee schedule.

Name of person consenting to exam: _____

Signature: _____ Date: _____