HEARING IMPAIRMENTS
TREATING PHYSICIAN
DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PHYSICIAN'S NAME AND ADDRESS

PHYSICIAN'S TELEPHONE

PHYSICIAN'S EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB
Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐
Initial CDR ☐ Hearing Officer ☐
Administrative Law Judge ☐ Appeals Council ☐
Federal District Court ☐ Federal Appeals Court ☐

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

Note 1: This document will not have legal validity for Social Security disability determination purposes in regard to diagnosis, exertional or other functional restrictions, unless completed by a licensed medical doctor (M.D.) or osteopath (D.O.). A medical doctor or osteopath must complete this form.

Note 2: This document only concerns hearing impairments. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

"A.S." means left ear.

"A.D." means right ear.

"dB" means decibels.

I. Does the person have a hearing impairment?

☐ **Yes** ☐ **No** ☐ **Unknown**

Date diagnosed

A. Significant hearing loss right ear

☐ **Yes** ☐ **No** ☐ **Unknown**

B. Significant hearing loss left ear

☐ **Yes** ☐ **No** ☐ **Unknown**

II. Describe type of hearing loss (sensorineural, otosclerosis, otitis media, etc.)

III. Treatment and response

A. Surgery

☐ **Yes** ☐ **No** ☐ **Unknown**

(If **Yes**, please briefly describe surgery and attach operative note.)

B. Medication

☐ **Yes** ☐ **No** ☐ **Unknown**

(If **Yes**, please list drugs prescribed for this disorder, including dosage and schedule, and any reported side-effects.)

C. Aided hearing?

☐ **Yes** ☐ **No** ☐ **Unknown**

A.D. ☐

A.S. ☐

Cochlear implant ☐

If unable to use aided hearing, please explain.

IV. Audiometric testing (if done, please attach copy)

A. Adults only (if less than 18 years of age, skip to **B**)

1. Unaided air conduction threshold sensitivity: average of 500, 1000, 2000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

1a. Unaided bone conduction threshold sensitivity: average of 500, 1000, 2000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

2. Aided air conduction threshold sensitivity: average of 500, 1000, 2000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

2a. Aided bone conduction threshold sensitivity: average of 500, 1000, 2000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

B. Children only (less than 18 years of age)

3. Unaided air conduction threshold sensitivity: average of 500, 1000, 2000, 3000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

3a. Unaided bone conduction threshold sensitivity: average of 500, 1000, 2000, 3000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

4. Aided air conduction threshold sensitivity: average of 500, 1000, 2000, 3000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

4a. Aided bone conduction threshold sensitivity: average of 500, 1000, 2000, 3000 Hz

A.D. _____ (dB)

A.S. _____ (dB)

C. Adults and children

5. Unaided speech discrimination

A.D. _____ (percent)

A.S. _____ (percent)

6. Aided speech discrimination (where possible)

A.D. _____ (percent)

A.S. _____ (percent)

V. Specific residual functional capacities and limitations.

(Note: This space applies only to patients at least 18 years of age. For young children, please discuss any known limitations in age-appropriate activities in **Section VI**.)

A. Can understand most speech in a quiet environment.

☐ **Yes** ☐ **No** ☐ **Unknown**

B. Can understand most speech in a noisy environment.

☐ **Yes** ☐ **No** ☐ **Unknown**

C. Can effectively use a telephone with aids.

☐ **Yes** ☐ **No** ☐ **Unknown**

Please use this space to discuss any specific capacities or limitations (related to hearing) you think may be relevant to a work environment.

VI. For children under age 18 only.

Does the child have a speech and language disorder which significantly affects the clarity and content of speech, and is attributable to the hearing impairment?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, is there a speech pathology report available?

☐ **Yes** ☐ **No** ☐ **Unknown**

VII. Additional Physician Comments

_____

Physician's Name (print or type)

_____

Physician's Signature (no name stamps)

_____

Date