Fill in this form if you’ve had an accident that’s affected your hearing. We’ll use the information you give us to work out how we can help you with your hearing loss.

When you’ve finished, please return this form to the person who’s been helping you with your claim.

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| 1. Your details | |
| Your name: [Client full name auto] | Claim number: [Claim number auto] |
| Date of birth: [Client date of birth auto] | Date of injury: [Date of injury auto] |

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| 2. ACC details | |
| ACC contact person: [AUTO: Staff member] | ACC office: [AUTO: ACC office] |

|  |  |
| --- | --- |
| 3. Representative details | |
| If it makes it easier for you, you can have someone else talk to us about your hearing loss claim. This can be a friend, a family member or anyone else you trust to talk to us on your behalf. If you want to do this, fill in the details below and then we can talk to your representative about your hearing loss claim. | |
| Representative’s name: | Relationship to you eg partner, friend: |
| Address: | |
| Phone number: | Email address: |
| I authorise the above person to talk to ACC about my hearing loss claim. I understand that this person is authorised to talk only about my hearing loss claim and I can write to ACC at any time to cancel this authority. | |
| Signature: | Date: |

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| 4. Accident details |
| Where did the accident happen? |
| What happened? |

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| 5. Treatment details | | |
| When did you first see someone for treatment after your accident? | | |
| What treatment did your doctor(s) recommend for your hearing loss? | | |
| Have you been referred to an audiologist? | Yes | No |
| If you’ve been referred to an audiologist, do you have an appointment yet? | Yes | No |
| What’s the audiologist’s or audiology clinic’s name? | | |
| Have you been referred to an Ear, Nose and Throat (ENT) specialist? | Yes | No |
| If yes, do you have an appointment yet? | Yes | No |
| What’s your ENT specialist’s name? | | |
| Please list the names and addresses of any treatment providers that you have seen about your accident: | | |

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| 6. Hearing loss details | | | | | |
| When did you first notice a problem with your hearing? | | | | | |
| What made you notice something wasn’t right? | | | | | |
| Are both ears affected? | Yes | No | If not, which is affected? | Left | Right |
| Have you had any pain with your hearing loss? | | | | Yes | No |
| If yes, when did you notice it? | | | | | |
| Have you noticed any other problems with your ears since your accident? | | | | Yes | No |
| If yes, please tell us about any other problems you’ve had with your ears since your accident: | | | | | |
| Did you ever have any problems with your ears before your accident? | | | | Yes | No |
| If yes, please tell us about when you’ve had any problems with your ears and what the problems were: | | | | | |
| Please tell us anything else you’d like us to know about your hearing loss: | | | | | |

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| 7. Hearing test details | | |
| Before your accident, had you ever had your hearing tested at work or at a hearing loss clinic? | Yes | No |
| If yes, when and where was your hearing tested? | | |
| I have attached a copy of any hearing test results I have to this questionnaire | | |

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| 8. Declaration and signature | |
| I confirm that to the best of my knowledge, the information I’ve provided on this form is true and correct. I authorise ACC to contact the doctors or specialists listed on this form, if more information is needed to help make a decision about my claim. | |
| Signature: | Date: |

When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC’s privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.