Please complete this form if you’re a provider and you need to describe the hearing needs and rehabilitation plan for a client under 18. Keep this form for your records and email a copy to the appropriate ACC Service Centre using the email address listed below.

|  |
| --- |
| 1. Client details |
| Client name: [Client full name auto]  | Claim number: [Claim number auto] |
| Address: [Client address line 1 auto], [Client address line 2 auto], [Client address line 3 auto], [Client address postcode auto] |
| Total hearing loss:      % | Please attach current audiogram |

|  |
| --- |
| 2. Assessment details |
| Vendor name:       | Vendor and facility codes:       |
| Provider name:       | Provider number:       |
| Assessment date:       |

|  |
| --- |
| 3. ACC details |
| ACC staff member: [Staff member auto] | ACC office: [ACC office auto] |
| Contact phone number: [Phone number auto] | Email address: Hamilton.hearingloss@acc.co.nz or Dunedin.hearingloss@acc.co.nz |

|  |
| --- |
| 4. Rehabilitative devices |
| Please give details of current or previous rehabilitative devices and the reasons for replacement:      |

|  |
| --- |
| 5. Hearing needs |
| Please identify the nature of the client’s hearing loss and specific listening needs in relation to language development, relationships, learning and educational environments:      |

|  |
| --- |
| 6. Rehabilitation plan |
| Please provide details below of the options you have recommended to address the client’s goals. |
| [ ]  Trial of hearing aids:  |
|  | Identify the features needed: |
|  | [ ]  Directional - fixed | [ ]  Directional - adaptive | [ ]  Noise reduction | [ ]  Feedback control |
|  | [ ]  Other. Please specify what they are and how they will help meet the client’s needs:       |
|  | Give details of the aids selected |
|  | Need: [ ]  Unilateral [ ]  Bilateral |
|  | Specific brand and model:       |
|  | Itemised cost of specific model: $      |
|  | For children in education, are these devices FM compatible?  | [ ]  Yes [ ]  No, please give rationale:       |
|  | Style: |
|  | [ ]  Receiver in the ear canal (RITC) | [ ]  Behind the ear (BTE)  | [ ]  In the ear (ITE) |
|  | [ ]  In the canal (ITC) | [ ]  Contralateral Routing of Offside Signals (CROS) |
|  | [ ]  Completely in canal (CIC)  | [ ]  Bilateral Contralateral Routing of Offside Signals (BiCROS) |
|  | Accessories:       |
|  | If applicable, how will the accessories assist in meeting the client’s needs?       |
| [ ]  Assistive device(s)/services: |
|  | What device(s)/services do you recommend?       |
|  | Itemised costs for recommended device(s)/services:       |
|  | How will these assist in meeting the client’s needs?       |

|  |
| --- |
| 7. Other comments |
| Please provide any other comments about the client’s rehabilitation plan and/or product choice:      |

|  |
| --- |
| 8. Assessor declaration and signature |
| I have considered all options, including product type and cost, and have recommended the best option to meet the client's needs. |
| 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.