BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

VETERAN REFERRAL QUESTIONNAIRE:

PLEASE FILL THIS FORM OUT TO THE BEST OF YOUR ABILITY. THANK YOU FOR YOUR SERVICE.

1) Today's Date: _____
2) Name: _____
3) Date of Birth: _____
4) Age: _____
5) Social Security Number: _____
6) Gender (**CIRCLE ONE**): **Male** or **Female**
7) Primary Language: _____
8) Email Address: _____
9) Home Phone Number: _____ Cell Phone Number: _____
10) Address: _____

    City: _____ State: _____ Zip Code: _____
11) Current Employment (**CIRCLE ONE**): **Full-Time** **Part-time** **Retired** **Unemployment** **Stay at home** **Student**
12) Current Employer: _____
13) Position: _____
14) If retired, list Prior Ocupation: _____
15) Family Doctor: _____
16) Do you currently wear hearing aids (**CIRCLE ONE**): **Yes** or **No**
17) Do you feel you have a hearing loss (**CIRCLE ONE**): **Yes** or **No**
    a) If yes, which ear? (**CIRCLE ONE**)**:** **Left Ear** **Right Ear** **Both Ears**
18) Do you have Dizziness or Unsteadiness (**CIRCLE ONE**): **Yes** or **No**
    a) If yes, do you have vomiting, nausea, or ear noises (**CIRCLE ONE**): **Yes** or **No**
    b) If yes, please explain: _____
19) Do you have Ear deformity (**CIRCLE ONE**): **Yes** or **No**
20) Do you have Ear drainage (**CIRCLE ONE**): **Yes** or **No**
21) Do you have Ear pain or History of ear infections (**CIRCLE ONE**): **Yes** or **No**
    a) If yes, please explain:_____
22) When was your last hearing test? _____
23) Where? _____
24) Were you a right or left-handed shooter? (**CIRCLE ONE**): **RIGHT** or **LEFT**

25) Is the Veteran Homeless (**CIRCLE ONE**): **Yes** or **No**

26) Are you having thoughts of **(CIRCLE ALL THAT APPLY)**: **Suicide** **Homicide** **None**

27) Are you experiencing domestic violence or partner violence? (**CIRCLE ONE**): **Yes** or **No**

28) Are you experiencing child or vulnerable adult abuse? (**CIRCLE ONE**): **Yes** or **No**

29) Did you bring your medical records or any information you'd like the VA to have that they do not have already? (**CIRCLE ONE**): **Yes** or **No**

    a) If yes, please explain: _____

30) What is your main complaint (**CIRCLE ONE**): **Hearing Loss** **Tinnitus (ringing in the ears)** **Both**

31) Please explain Hearing Loss and Tinnitus Issues: _____

    a) If something else, please explain: _____

32) Do you think the military caused your hearing loss? (**CIRCLE ONE**): **Yes** or **No**

    a) If yes, please explain: _____

33) **WHEN** did your hearing loss start (**PLEASE LIST APPROXIMATE DATE**): _____

    a) **HOW** did your hearing loss start? _____

    b) **WHAT EVENT** do you remember when hearing loss started? _____

34) What difficulties, if any, does the Veteran have with their hearing? (**CIRCLE ALL THAT APPLY**)**: Hearing is fine** **Able to hear but not clearly** **Difficulty in noisy or group environments** **Other:** _____

35) Pertinent Military Service History (Evidence: DD214):

    a) Branch of service: _____

    b) AFSC/MOS/Job in the Military: _____ MOS #: _____

    c) Dates of service (**MONTH/YEAR if known**): _____ to _____

    d) Number of years in service: _____

    e) Pertinent decorations or medals or ribbons (**CIRCLE ANY THAT APPLY**): **Purple Heart, Combat Action Badge, Combat Infantry Badge, Meritorious Achievement Badge, AAM, Good Conduct Medal, Global War on Terrorism, Overseas Ribbon, ARCOM, None,** Others: _____

36) Did you serve during Peacetime (a period when a country is not at war)? (**CIRCLE ONE**): **Yes** or **No**

37) Did you serve during Combat (fighting between armed forces)? (**CIRCLE ONE**): **Yes** or **No**

38) Did you serve during Combat time but did not go to the conflict/war? (**CIRCLE ONE**): **Yes** or **No**

HISTORY OF MILITARY NOISE EXPOSURE:

39) Did you have Military Noise Exposure while you were in the service (**CIRCLE ALL THAT APPLY**):

    Explosions **Firearms** **Artillery** **Aircraft Noise** **Heavy Equipment** **Generators**

    a) Please list details of any other Military Noise Exposure: _____

40) Did your military job require you to be in noise (**CIRCLE ONE**): **Yes** or **No**

    a) If yes, please explain: _____

41) Did you wear ear protection (**CIRCLE ONE**): **Yes** or **No**

a) If no, why didn't you wear ear protection? (**PLEASE EXPLAIN**): _____

HISTORY OF OCCUPATIONAL NOISE EXPOSURE (Examples: Aircraft, Farm Equipment, Heavy Equipment, Power Tools, Etc.):

42) **BEFORE** you were in the service did you work around noise (**CIRCLE ONE**): **Yes** or **No**

a) **If yes, please explain**: _____

43) **AFTER** you were in the service did you work around noise (**CIRCLE ONE**): **Yes** or **No**

a) **If yes, please explain**: _____

HISTORY OF RECREATIONAL/ SOCIAL NOISE EXPOSURE (During your free time, not working or during service):

44) **BEFORE** you were in the service were you exposed to **Recreational/Social Noise**? (**CIRCLE ALL THAT APPLY**):

Motorcycles **ATV** **Firearms** **Power tools** **Loud Music/Concerts** **None**

List any other recreational noise exposure not listed: _____

45) **DURING** your time in the service were you exposed to **Recreational/Social Noise**? (**CIRCLE ALL THAT APPLY**):

Motorcycles **ATV** **Firearms** **Power tools** **Loud Music/Concerts** **None**

List any other recreational noise exposure not listed: _____

46) **AFTER** you were in the service were you exposed to **Recreational/Social Noise**? (**CIRCLE ALL THAT APPLY**):

Motorcycles **ATV** **Firearms** **Power tools** **Loud Music/Concerts** **None**

List any other recreational noise exposure not listed: _____

FAMILY HISTORY OF HEARING LOSS:

47) Does anyone related to you have hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please list relation (Example: mother, father, uncle, grandfather or grandmother, etc.)

_____

HEARING LOSS:

48) Have you had a surgery that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

49) Have you had chemo/ radiation treatments that have caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

50) Have you had head trauma that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

51) Have you taken long-term IV antibiotics that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

52) Have you had an acoustic neuroma (ear tumor) that has caused hearing loss (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

53) Do you have signs of dementia or cognitive decline? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain: _____

54) Does hearing loss affect your daily activities? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please describe (**or circle all that apply**): Phone calls Difficulties in background noise TV is louder Conversations with others Other: _____

55) What daily life hearing difficulties do you have? _____

56) How does hearing loss affect your work environment? _____

MUST ANSWER ALL TINNITUS QUESTIONS, VA WILL DENY IF NOT ANSWERED!

57) Do you have tinnitus (i.e., ringing in the ears, humming, rushing, buzzing, clicking)? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, which ear is the ringing? (**CIRCLE ONE**)**: Left Ear Right Ear Both Ears**

b) If yes, please describe (**or circle all that apply**): Ringing Humming Ticking Rushing Thumping Squealing Wind Buzzing High Pitch Low Pitch Loud Quiet Other: _____

58) Does the loudness of your tinnitus make it difficult for you to hear people? (**CIRCLE ONE**): **Yes** or **No**

59) Do you have tinnitus when you are laying down or trying to fall asleep? (**CIRCLE ONE**): **Yes** or **No**

60) Is the tinnitus constant? **(CIRCLE ONE): Yes** or **No**

61) Is the tinnitus intermittent (on & off)? **(CIRCLE ONE): Yes** or **No**

a) If yes, describe how often: _____ times per day _____ times per week

b) If yes, how long does each episode last? _____ seconds _____ minutes _____ hours

62) What do you think caused your tinnitus? _____

63) Has your tinnitus changed since initial onset? **(CIRCLE ONE): Yes** or **No**

a) If yes, please describe (**or circle all that apply**): Louder Change in Pitch Duration Other: _____

64) What date did the tinnitus start (can be approximate date)? _____

65) Does your tinnitus affect daily activities? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please explain (**or circle all that apply**): Phone calls Daily tasks Sleep Conversations with others Other: _____

66) Does your tinnitus (ringing in the ears) affect your work activities? (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please describe how: _____

67) Do you think your tinnitus was caused by your military services (**CIRCLE ONE**): **Yes** or **No**

a) If yes, please describe how: _____

BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

HIPAA/Communication/Consent to Treatment

Our Notice of Privacy Practices provides information about how we may use and disclose protected information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting Baker Audiology.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy dated January 2014 (copy available at the front desk).

Communication with Optum Serve (formerly LHI)

Baker Audiology may share medical and/or billing information with the following individuals who are involved with the patient's care:

Release to: Optum Serve (formerly LHI)

Wireless Communications

I hereby agree that by providing my wireless/cell phone number, I am, hereby granting my consent to receive communication on my wireless/cell phone number for business related to my healthcare services or payment thereof. Methods of contact may include messages on your phone directly from our office on your voicemail and text messages.

◯ Decline

Authorization for Treatment

I consent to treatment for myself or my family from Baker Audiology & Hearing Aids:

Signature of patient: _____

Printed name of patient: _____

Signature of representative if other than patient: _____

Printed name of representative if other than patient:_____

Relationship to patient:_____

Time: _____

Date:_____

BAKER AUDIOLOGY
& HEARING AIDS

429 W 69th St, Sioux Falls, SD 57108
Phone: 605-306-5756 / Fax: 605-306-5676

Policy, billing and release of medical records Authorization, Notice of privacy practices acknowledgment of receipt:

*We will gladly bill Optum Serve (formerly LHI), you will not be responsible for any of the billing for services provided today.
Please Initial _____

*I request that payment of authorized benefits be made on my behalf to **Baker Audiology & Hearing Aids** for services furnished to me by the provider. I authorize Optum Serve to release medical information about me to **Baker Audiology & Hearing Aids**. Any information needed to determine these benefits or the benefits payable for related services.
Please initial:_____

*I acknowledge that I have been given the opportunity to read the notice of privacy practices for the office of **Baker Audiology & Hearing Aids**. A copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.
Please initial:_____

*In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request through Optum Serve.
Please initial: _____

*I acknowledge that my audiologist may use a secure, HIPAA-compliant artificial intelligence (AI) tool to assist in generating chart notes based on our visit. This tool is used soley to improve the accuracy and efficiency of documentation. My personal health information will be handled with strict confidentiality and in accordance with all applicable privacy laws.
Please initial: _____

Signature of Patient: _____

Signature of Parent or Guardian: _____

**** Please provide our front desk staff with your insurance card****