Veterans Affairs Canada — Anciens Combattants Canada

Protected B when completed.

Medical Questionnaire: Hearing Loss/Tinnitus

CSDN ID	File No.

Last name*	First name*	Middle name(s)
Date of birth (yyyy-mm-dd)	Date of examination (yyyy-mm-dd)	Decision No.
Mailing address (No., Street, Apartment No., PO Box, RR No.)		City/Town/Village

Country	Province/Territory/State	Postal Code/ZIP

Very specific information is required by Veterans Affairs Canada (VAC) to evaluate and assess a client's claimed/ entitled condition(s). This information can be provided with one of the following options:

<u>OPTION 1</u> - complete the following medical questionnaire, OR

<u>OPTION 2</u> - submit a detailed report which includes all the information requested in this medical questionnaire.

CONFIRMED MEDICAL DIAGNOSIS(ES) OF HEARING LOSS/TINNITUS:

MEDICAL HISTORY - Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors. Include injury(ies), with dates, if applicable.

(Add any additional comments on the last page.)

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS.
(e.g., Consultation(s), hospital discharge summary(ies), diagnostic imaging)

Fields with an asterisk (*) are required.

Ce formulaire est disponible en français.

Canada

Last name*	First name*	CSDN ID	File No.

HEARING LOSS ☐ Not Applicable

If confirmed medical diagnosis of hearing loss, please attach a recent audiogram (not more than 2 years old) which includes the following information:

1. Hearing tested for both air and bone conduction at 500, 1000, 2000, 3000, 4000, 6000 and 8000 hertz frequency in both ears.
2. An indication of reliability of the audiogram by the audiologist.
3. SRT (Speech Reception Threshold) for both ears.
4. A narrative interpretation of results by a registered clinical/audiologist or a physician.

TINNITUS ☐ Not Applicable

How long has the tinnitus been present? ______________________

If a hearing aid is worn, does it have an attached or built-in masker? Yes ◯ No ◯

Please choose the most appropriate statement:

- Present less than once a week ◯
- Present at least once a week ◯
- Present daily but not all day long ◯
- Present all day and night but does not require use of a masking device ◯
- Present all day and night and requires the ongoing use of a masking device ◯

When prescribed medications, supporting documentation from the physician must be provided.

Treatment

Medication list (include dosage, frequency, duration, route and response).

Surgery/Hospitalization (include date(s) and response).

Are further relevant diagnostic test(s) or consultation(s) ongoing or planned? Yes ◯ No ◯

Describe any complications resulting from the hearing loss/tinnitus.

Fields with an asterisk (*) are required.

Last name*	First name*	CSDN ID	File No.

ADDITIONAL INFORMATION

Privacy Notice

Veterans Affairs Canada (VAC) is committed to protecting individuals' privacy rights, including safeguarding the confidentiality of the information provided. The information provided on this form is collected under the authority of the *Pension Act*, the *Veterans Well-being Act*, the *Royal Canadian Mounted Police Superannuation Act* and/or the *Royal Canadian Mounted Police Pension Continuation Act* for the purpose of determining disability entitlement and/or assessment. Providing this information is voluntary. However, an incomplete form may cause delays for the individual. This personal information may be shared for case management purposes, to determine eligibility for additional benefits, or for commemorative activities, where applicable. The recorded opinion about an individual is considered personal information about and belonging to that individual. The individual to whom this information belongs has the right to the correction of, access to, and protection of their personal information under the *Privacy Act* and to file a complaint with the Privacy Commissioner of Canada, at 30 Victoria Street, Gatineau, QC, K1A 1H3, over VAC's handling of their information. Additional information about how VAC handles personal information can be found in the Information about Programs and Information Holdings publication found on VAC's website.

Health care professional's name (last name, first name)

Address (No., Street, Apartment No., PO Box, RR No.) | City/Town/Village

Country | Province/Territory/State | Postal Code/ZIP

Telephone (Country Code, Area Code, No.) ( ) | Is VAC to be invoiced? Yes ◯ No ◯

Health care professional's signature | Today's date (yyyy-mm-dd)

Fields with an asterisk (*) are required.