

## Medical Clearance Form for Hearing Test

<b>Patient Name:</b> _____ <b>Phone Number:</b> (____) _____
<b>Address:</b> _____ _____

It is in your best health interest to have a medical evaluation by a physician. This medical clearance form is required for individuals who have or suspect any of the following conditions:

- Visible congenital or traumatic deformity of the ear
- Current ear infection
- History of active drainage from the ear within the past 90 days
- Sudden or rapid progression of hearing loss within the past 90 days in one or both ears
- Acute or chronic dizziness
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
- Pain or discomfort in the ear
- Individuals with poor dexterity, poor vision, or significant dementia
- Fluctuating hearing sensitivity
- Sudden onset or rapid worsening of tinnitus within the past 90 days
- History of conductive or mixed hearing loss or ear surgery

<b><i>To be completed by a Physician</i></b>	
The following information relates to _____, a patient in my care. <i>Patient Name</i>	
I evaluated this patient's health within the last three months. This patient may be considered a candidate for a hearing test.	
_____ <i>Physician's Signature</i>	_____ <i>Date</i>
_____ <i>Phone</i>	

**Fax:** (510) 686-8560    **e-mail:** [audiology@ihearmedical.com](mailto:audiology@ihearmedical.com)    **Mail:** **Audiology, iHear Medical, Inc.**  
15250 Hesperian Blvd. Suite 102  
San Leandro, CA 94578