HEAR2UNDERSTAND
AUDIOLOGY SERVICES

1112 MORGAN AVE. BAY B SASKATOON, SK S7H2R7
PHONE 306-716-7143 FAX 306-384-4184

PERSONAL INFORMATION FORM

FIRST NAME:_____

LAST NAME:_____

BIRTHDATE (dd/mm/yyyy):_____AGE:_____

PRONOUNS: SHE/HER HE/HIM THEY/THEM OTHER:_____

PARENTS/GUARDIANS (if applicable):_____

_____

ADDRESS:_____

CITY/TOWN:_____POSTAL CODE_____

HOME/CELL PHONE:_____

WORK PHONE (optional):_____

EMAIL (optional):_____

3RD PARTY ID# (VAC/NIHB/SHP/WCB):_____

Provincial Health Card #:

SIGNATURE:_____ DATE: _____

(IF SIGNED BY PARENT/GUARDIAN/NEXT OF KIN:_____)

(PLEASE PRINT NAME)

HEAR2UNDERSTAND
AUDIOLOGY SERVICES

1112 Morgan Ave, Bay B Saskatoon, SK S7H 2R7 Phone 306-716-7143 Fax 306-384-4184

CONSENT TO COLLECT PERSONAL INFORMATION & CONSENT TO TREATMENT

OUR COMMITMENT TO PRIVACY

The appropriate collection, use and disclosure of clients' personal health information is fundamental to our operations and to your care. We strive to provide you with excellent hearing health care and services, which includes treating your personal information with respect. Each employee of Hear2Understand Audiology Services must abide by our commitment to privacy in the handling of personal information.

CONSENT TO COLLECT INFORMATION

I have read and understood the privacy policy statement located on the back of this form that outlines how my personal information will be collected, used, disclosed and protected. I understand my rights to review this personal information, which will be used to provide me with hearing services. In some instances, I may ask for specific information not to be collected. I understand that the Audiologist in her discretion may make use of all other records that would permit her to complete the investigation and follow-up regarding my hearing status.

CONSENT TO TREATMENT

I also consent to undergo all hearing-related exams and procedures by the professional staff at Hear2Understand Audiology Services

Signature: _____ **Date** _____

Print Name: _____

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorise Hear2Understand Audiology Services to disclose copies of the health record (audiograms, reports, etc.) and conduct other necessary correspondence related to the hearing health care of:

CLIENT/PATIENT NAME:

_____**DOB:** _____

TO: *(please provide name and phone number if possible)*

☐ Next of Kin / Family member(s) / POA

_____

☐ Physician(s)_____

☐ ENT/Otologist _____

☐ SLP_____

☐ School / Teacher _____

☐ Travel Coordinator_____

☐ Other_____

Third Party:

☐ FIHP ☐ NIHB ☐ SHP ☐ VAC ☐ WCB

I ACKNOWLEDGE THAT THIS INFORMATION IS CONFIDENTIAL. I ACCEPT THE RESPONSIBILITY FOR THE SAFEKEEPING OF THIS INFORMATION. HEAR2UNDERSTAND AUDIOLOGY SERVICES, ITS AGENTS AND EMPLOYEES ARE RELIEVED OF ANY RESPONSIBILITY RESULTING FROM REPRODUCTION OR FURTHER USE OF THE INFORMATION RECEIVED OTHER THAN STATED ON THIS FORM.

This consent must be signed by the client/patient or their legal next of kin in accordance with Health Information Protection Act (HIPA) legislation.

_____ _____

Signature **Relationship to Client/Patient**

Date: _____

HEAR2UNDERSTAND
AUDIOLOGY SERVICES

1112 MORGAN AVE. BAY B SASKATOON, SK S7H2R7 PHONE 306-716-7143 FAX 306384-4184

PERSONAL EMAIL COMMUNICATIONS CONSENT

Client Name: _____

PARENTS/GUARDIANS (if applicable):_____

EMAIL ADDRESSES: _____

I _____, request and authorize Hear2Understand Audiology Services to communicate information with me regarding aspects of my hearing healthcare through the above email addresses. My signature below indicates I accept the risk of loss of privacy of confidential health information associated with email communication.

I agree that Hear2Understand Audiology Services shall not be liable for any type of damage or liability arising from or associated with the loss of confidentiality due to email communication that is not caused by the hearing health care provider's intentional misconduct. I understand Hear2Understand Audiology Services will use reasonable means to protect the security and confidentiality of email information sent and received. Further I understand Hear2Understand Audiology Services does not guarantee this means of communication will be free from technological difficulties including, but not limited to, loss of messages or delay of transmission.

This authorization for communication by means of email is valid until I notify Hear2Understand Audiology Services, in writing, that I no longer authorize the use of email to communicate information concerning my hearing healthcare. Hear2Understand Audiology Services also retains the right to terminate email as a communication option if it is not used appropriately.

SIGNATURE: _____ DATE:_____

(IF SIGNED BY PARENT/GUARDIAN/NEXT OF KIN: _____)

(PLEASE PRINT NAME)

10 PRINCIPLES OF PRIVACY

Principle 1 – Accountability: We take our commitment to securing your privacy seriously. The staff associated with this practice is responsible for the personal information under its control. Staff are informed about the importance of privacy and receive information periodically to update them about our Privacy Policy, confidentiality, and related issues.

Principle 2 – Identifying Purposes: *Why we collect information* – We ask for personal information to establish a relationship and to serve your medical needs. We obtain most information directly from you or from other health practitioners whom you have seen and have authorised to disclose information to us. We will limit the information that we collect and will use it only for those purposes. We will obtain your consent if we wish to use your information for any other purpose.

Principle 3 – Consent: For most health care purposes your consent is implied due to your consent to treatment, however sometimes written consent may be required.

Principle 4 – Limiting Collection: We only collect information for purposes related to the provision of your medical care.

Principle 5 – Limiting Use, Disclosure, and Retention: We will seek your consent before using the information for purposes beyond the scope of our privacy statement. Under no circumstances do we sell patient lists or other personal information to third parties.

Principle 6 – Accuracy: While we do our best to base our decisions on accurate information, we rely on you to disclose all material information and to inform us of any relevant changes.

Principle 7 – Safeguards: *Protecting your information* – The practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individuals' personal information are securely stored in files held onsite in our office. If required, older records may be stored offsite. Only authorised personnel will be granted access to these private records.

Principle 8 – Openness: *Keeping you informed* – If you have any additional questions or concerns about privacy, please ask. We would be more than happy to give you more details upon your request.

Principle 9 – Individual Access: We will give you access to the information we retain about you within a reasonable time. We may charge a fee for this and if so, we will give you notice in advance of processing your request. Please note, we are not required to correct information relating to clinical observations or opinions made in good faith.

Principle 10 – Challenging Compliance: We encourage you to contact us with any questions or concerns you might have about our Privacy Policy. If you are still not satisfied we can provide further complaint procedures available to you.

These principles are usually referred to as "fair information principles". They are included in the *Personal Information Protection and Electronic Documents Act* (PIPEDA), Canada's private-sector privacy law.

CHILDHOOD HEARING QUESTIONNAIRE

NAME OF CHILD: _____BIRTHDATE:_____

PARENT(S) AND/OR GUARDIAN(S):_____

1. For what reason was this hearing test arranged?

_____

2. Has your child ever had a hearing test? **Yes** **No**

If YES, where & when?_____

What was result of test? _____

3. Do you have any concerns about your child's hearing? **Yes** **No**

Does your child seem to hear better on some days than others? **Yes** **No**

4. Does your child complain regularly about sounds being too loud? **Yes** **No**
5. Does your child complain about ringing in their ears? **Yes** **No**
6. Does anyone in the family (sisters, brothers, parents, aunts, grandparents, etc.) have a history of hearing loss in childhood or at a young age ? **Yes** **No**

If YES, please provide details:_____

7. Were there any complications during pregnancy or delivery? **Yes** **No**
8. Were any of the following present after your child's birth or during the first two months ?

☐ Stayed in hospital after mother
☐ Prematurity
☐ Birth weight less than 1500 g (3.3 lbs.)
☐ Infections
☐ Did not respond to sounds or people
☐ Poor weight gain
☐ Was in an incubator or isolette
☐ Appeared yellow/jaundiced
☐ Difficulty breathing/ventilation needed
☐ Brain problems
☐ Heart problems
☐ High fever

9. What is your child's general health? **Good** **Poor**
10. Is your child taking any medication now? **Yes** **No**
11. Has your child ever been hospitalized? **Yes** **No**

12. Has your child had ear infections or other ear disorders? **Yes** **No**

If YES, please provide details:_____

13. Has your child had any ear surgery (e.g. tubes, eardrum repair)? **Yes** **No**

If YES, please provide details:_____

What illnesses has your child had?_____

_____

☐ High fever
☐ Pneumonia
☐ Convulsions/Seizures
☐ Heart problems
☐ Encephalitis
☐ Meningitis
☐ Rheumatic fever
☐ Head or ear injury
☐ Allergies_____
☐ Asthma
☐ Tonsillitis
☐ Other: _____

14. Has your child ever received speech therapy? **Yes** **No**

15. Do you have any concerns about your child's speech and language? **Yes** **No**

List any languages that your child is exposed to:

_____

16. Do you have any concerns about your child's physical or mental development? **Yes** **No**

If YES, please provide details:_____

17. Do you have concerns about your child's balance (e.g. veering, falling often)? **Yes** **No**

18. Does your child have any behavioural issues? **Yes** **No**

If YES, please provide details:_____

19. Do you have concerns about your child's progress in school? **Yes** **No**

SIGNATURE:_____ DATE: _____

Adapted from: BC Early Hearing Program BCEHP-Childhood Hearing Questionnaire – JANUARY 2018