

Claim Number (if known)

To avoid delays, please complete in full printing in black ink.

A. Patient & Employer Information Section (Patient to Complete this Section)

Last Name						First Name						Init.
Address (no. street, apt.)												
City/Town						Prov.	Postal Code			Telephone No.		
Date of Birth	dd	mm	yy	Date of Accident	dd	mm	yy	Date of Assessment	dd	mm	yy	Sex <input type="checkbox"/> M <input type="checkbox"/> F
If return to work is considered, has the employer been contacted? <input type="checkbox"/> yes <input type="checkbox"/> no												
Employer Name						Supervisor/Contact Name						
Address (no. street, apt.)												
City/Town						Prov.	Postal Code			Telephone No.		

B. Health Professional/Service Provider Billing Information

Health Professional/Service Provider Name (please print)						Service Code NIHCOS		
Facility						▼ Complete these fields if HST is applicable to this form ▼		
Address (no. street, apt.)						HST Registration No.	Service Code	HST Amount Billed
City/Town						ONHST \$.		
Prov. Postal Code Telephone No. Extension Fax No.						WSIB Provider ID.		
						Your Invoice No.		

C. Outcome Measurement (COSI™- Client Oriented Scale of Improvement)

COSI™ yes (please attach) no (please explain)

If no, explain

A. Degree of change COSI™ column totals	Worse	No Difference	Slightly Better	Better	Much Better	=	Total # Category Identified A = B
B. Final ability COSI™ column totals	Hardly Ever	Occasionally	Half of the Time	Most of the Time	Almost Always	=	

D. Assessment of Barriers to Utilization of Hearing Aid

Do any of the following barriers exist?
 Physical Psychological Education

Please explain any barriers and treatment strategy

Signature of Health Professional/Service Provider

Date dd mm yy