print reset save

wsib ONTARIO

Mail To:
200 Front Street West
Toronto ON M5V 3J1

OR Fax To:
416-344-4684
OR 1-888-313-7373

NIHL Trial Period Follow-Up Form

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

start > Claim Number (If known)

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 ☐ M ☐ F

If return to work is considered, has the employer been contacted? ☐ yes ☐ 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)

Facility

Address (no. street, apt.)

City/Town

Prov.	Postal Code	Fax	Telephone No.	Extension

Service Code **NIHLTPF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration No.	Service Code **ONHST**	HST Amount Billed

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	=
B.	Final ability COSI™ column totals	Hardly Ever	Occasionally	Half of the Time	Most of the Time	Almost Always	=

Total # Category Identified A = B

LEFT SIDE	RIGHT SIDE
Manufacturer/Model	Manufacturer/Model
Serial Number	Serial Number
Style ☐ ITE ☐ ITC ☐ CIC ☐ BTE	Style ☐ ITE ☐ ITC ☐ CIC ☐ BTE
Comments:	Comments:

wsib ONTARIO

NIHL Trial Period Follow-Up Form

Last Name	First Name

Claim Number (If known)

D. Verification

Hearing instrument is appropriate for patient's maximum loudness tolerance level and required gain for audiometric configuration (frequency response): ☐ Yes ☐ No

Verification measures, labeled with respect to relative position of volume control, acoustic controls and stimulus input level are required.

Attached ☐ Real-Ear Measurements ☐ Sound Field Evaluation ☐ Other .....

Care and maintenance of hearing instrument(s) and patient expectations from hearing instrument(s) have been addressed. ☐ Yes ☐ No

E. Signature of Health Professional/Service Provider

I, ... (Print Name) the service provider, feel this hearing instrument fitting is subjectively appropriate.

Signature of Health Professional/Service Provider	Date dd mm yy
Please print, sign and date this form before returning to the WSIB	

F. Patient - Read Before Signing

I realize that I had up to 30 days to assess my hearing instrument(s). I now find that my hearing instrument(s) are beneficial to me and have decided to keep them. I understand that my hearing instrument(s) will be replaced only if necessary (e.g. change in hearing status beyond the tolerance of this current hearing instrument). If problems arise with my hearing instrument(s) I will return to the service provider in a timely manner.

Signature of WSIB Patient	Date dd mm yy
Please print, sign and date this form before returning to the WSIB	