

The University of Mississippi Medical Center
Cochlear Implant Program
(601) 815-6064 or (601) 815-6058

APPLICATION FOR COCHLEAR IMPLANT EVALUATION

Date: _____

PATIENT INFORMATION

Name: _____	Date of Birth: _____
Address: _____	
Phone Number: Home _____	Cell _____
Occupation: _____	Employer: _____
Spouse's Name: _____	
Name of Emergency Contact: _____	
Phone Number: _____	Relationship: _____
Referred By: _____	

HEARING

When was hearing loss identified: _____

What is the severity of your hearing loss? _____

Describe the cause of hearing loss, if known: _____

Date/location of last hearing evaluation: _____

Do you wear hearing aids? Yes No

In which ear(s)? Left Right Both

When did you first start wearing hearing aids? _____

How many hours are hearing aids worn each day? _____

If you no longer wear hearing aids, how long has it been since you stopped using them? _____

Why did you discontinue hearing aid usage? _____

COMMUNICATION

Primary language spoken in the home: _____

What is your primary mode of communication?

Spoken language Speech and sign language Sign language only

How much do you rely on lipreading in order to understand spoken language?

All of the time Some of the time None of the time

Are you able to talk on the phone? Yes No

If no, do you use a TTY? Yes No

If you do not communicate by phone/TTY, please provide name and phone number of person to be contacted regarding appointments:_____

EDUCATION

Describe K-12 educational placement (check all that apply):

- Regular classroom placement Special education placement
 Specialized school Other

List schools attended:_____

What is the highest grade you completed/highest degree earned?_____

MEDICAL BENEFITS

Patient has medical benefits through (check all that apply):

- Medicaid Medicare Insurance Other

If you have Medicaid, please provide your Medicaid number:_____

If you have private insurance, please complete the following:

Name of Carrier:_____

Primary Insured:_____

Policy/Identification Number:_____

OTHER

How did you learn about the cochlear implant?

How do you feel a cochlear implant would help you?

Please note any specific questions that you would like answered during your evaluation.

Would you like a sign language interpreter to be present during your evaluation?_____

Return completed form to:

**UMC/Dept. of Communicative Sciences
Attn: Lara Monico/JMM
2500 North State Street
Jackson, MS 39216**

OR FAX TO: (601) 815-4693