

CHILD & PARENT INFORMATION

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name(s): _____

Residential Address: _____

Postcode: _____

Home Phone: _____

Mobile: _____

Email: _____

Doctor's Name & Address: _____

REFERRAL SOURCE

How did you hear about Delta Hearing?

☐ GP/Doctor ☐ ENT/Specialist ☐ Workplace ☐ Newsletter ☐ Website ☐ Property Signage☐ Flyer/Mailout ☐ Google ☐ Facebook ☐ Family/Friend ☐ HSP/DVA ☐ Email Newsletter ☐ SMS☐ Other: _____Would you like to receive our newsletter? ☐ Yes ☐ No

AUDIOLOGICAL CASE HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. PRIMARY CONCERN

What is the main reason for your visit? _____

When was the issue first noticed? _____

How severe is the issue? _____

Any previous hearing assessments or treatments? _____

2. PRENATAL HISTORY

Exposure to viral infections during pregnancy? If yes, specify: _____

Which month of pregnancy? _____

Any medications or trauma during pregnancy? _____

3. BIRTH HISTORY

Gestational age at birth: _____ Birth weight: _____ History of asphyxia or meningitis? ☐ Yes ☐ NoHigh bilirubin levels? ☐ Yes ☐ No

Result of newborn hearing screening: _____

4. FAMILY HISTORY

Any childhood hearing loss in the family? ☐ Yes ☐ No

Relation to child: _____ Any known birth defects or genetic abnormalities? _____

5. DEVELOPMENTAL MILESTONES

First smile: _____ Age sat up alone: _____ First crawled: _____ First walked: _____
First words spoken: _____ Speech concerns? _____

6. MEDICAL HISTORY

Any of the following?

☐ Cleft lip/palate ☐ Abnormal ear shape ☐ High fevers ☐ Seizures ☐ Frequent ear infections ☐ Previous ear treatments

7. OTHER MEDICAL PROFESSIONALS

Child's Paediatrician: _____

Other involved specialists: _____

MEDICAL & PRIVACY CONSENT

Delta Hearing collects your personal and health information to provide comprehensive hearing care. This information is handled in compliance with the Privacy Act 1988 (Cth).

- By signing below, I acknowledge and consent to the following:
- My personal information may be shared with relevant health professionals or government agencies (e.g., Office of Hearing Services, WorkSafe) to facilitate care or funding.
- I understand that withholding personal information may limit the services Delta Hearing can provide.
- I consent to being contacted by Delta Hearing regarding appointments, hearing health updates, and relevant services via phone, email, SMS, or post.
- All data is securely stored within Australia and will not be disclosed internationally unless requested.
- Minor risks such as irritation or bleeding may occur during procedures like wax removal or ear impressions.
- I acknowledge I have informed the clinician of any medical conditions or medications that may affect treatment.
- Visit <https://www.deltahearing.com.au/privacy-policy> for our full Privacy Policy.

Client Name:

Signature:

Date:
