TRANSFER REPORT : Older Children and Adults

Referring Program:……

Audiologist: …… Date: ……
Referral to Cochlear Implant Program: ……

Recipient Particulars			
Surname		First name	
Date of birth		I.D No	
Name of mother		Name of father	
Residential address			
Postal address			
Home Tel	Cell	Business	Email

Case History Information		
	Right ear	Left ear
Age at onset of hearing loss		
Date of diagnosis of hearing loss		
Duration of deafness before implantation		
Use of hearing aids		
Pre-operative speech perception test scores		

Warble Tone Freefield Thresholds									
Date:									
	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									

Implant History		
	Right	**Left**
Date of initial surgery		
Implanting Surgeon		
Audiologist		
Hospital		
Implant Model		

Implant Serial Number		
Comment		
Sound Processor History		
	Right	**Left**
Initial stimulation date		
Current Processor Model		
Serial number		
Magnet strength		
Coil		
Cable		
Remote S/N		
Mapping		
	Right	**Left**
Speech coding strategy		
Mode		
Rate		
Maxima		
Pulse width		
Pre-processing		
Electrodes deactivated		
Comments:		

Warble Tone Freefield Thresholds									
Date:									
	250Hz	500Hz	750Hz	1000Hz	1500Hz	2000Hz	3000Hz	4000Hz	6000Hz
Right									
Left									

Speech Perception Scores					
Date:					
Test Items	Presentation Recorded/Live	Presentation Level	Right score	Left Score	Bimodal/ Bilateral

Recommendations