

## Outline for Otologic Evaluation

**U.S. Department of Labor**  
Office of Workers' Compensation Programs  
Division of Federal Employees' Compensation



OMB No. 1240-0046 Expiration Date: xx-xx-xxxx
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**NAME:**

**FILE NUMBER:**

**I. HISTORY:**

(A) Our adjudication and possible awards are based solely on the fact of causality of all or a portion of the loss arising from exposure related to Federal Civilian employment. The only history of noise exposure on which this case can be legitimately adjudicated is that defined by the Statement of Accepted Facts. If there is any variance in the history as given by the patient and that contained in the Statement of Accepted Facts, it should be carefully considered and commented upon, but the opinion you render must be based solely on the Statement of Accepted Facts.

IS THERE ANY SIGNIFICANT VARIATION FROM THE STATEMENT OF ACCEPTED FACTS?

(B) Please comment on this patient's hearing at the beginning of his/her significant noise exposure in Federal Civilian employment, if audiometric data is available.

(C) Compare, if possible, the present audiometric findings to those at the beginning of exposure. Does this individual show a sensorineural loss that is in excess of what would be normally predicated on the basis of presbycusis?

(D) Was the workplace exposure, as described in the material provided, sufficient as to intensity and duration to have caused the loss in question?

(E) Please provide all other relevant history facts, (such as other noise exposure) emotional disorders, systemic diseases, (such as diabetes) local infections, ototoxic drug usage, surgery, etc. as they relate to this individual's hearing loss sensorineural or conductive.

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If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.

**II. PHYSICAL EXAM**

Please make this as extensive as necessary in line with any findings bearing on this individual's hearing loss. If only a minimal note is required, please include at least the following:

Describe the canals and drums.

Drum Motility:

Result of Basic fork tests:

Is there indication of any medical condition such as an acoustic neuroma or meniere's disease? Please explain.

Is there indication of tinnitus? If yes, please address any limitations in Activities of Daily Living (ADLs) resulting from the tinnitus, including sleep, reading (and other tasks requiring concentration), enjoyment of quiet recreation and emotional-well-being.

Other:

**III. OPINION**

DIAGNOSIS:


If sensorineural or mixed, complete the following:

The sensorineural hearing loss seen is, in part or all, in my opinion

DUE

NOT DUE

to noise exposure encountered in this claimant's Federal civilian employment.

If tinnitus is diagnosed, complete the following:

The tinnitus is, in part or all, in my opinion

DUE

NOT DUE

to noise exposure encountered in this claimant's Federal civilian employment.

Medical rationale supporting the above position(s):

Recommendations:

Signature of Physician/Date \_\_\_\_\_

Expiration Date: XX-XX-XXXX

**IV. VERIFICATION OF AUDIOMETRIC TESTING**

Audiologist's Name \_\_\_\_\_

AUDIOGRAM IS ONLY ACCEPTABLE FOR USE IF AUDIOLOGIST IS AHSA CERTIFIED OR HAS A STATE LICENSE - REFER FOR TESTING IF OFFICE AUDIOLOGIST DOES NOT MEET THIS CRITERIA.

ASHA Cert. I.D. \_\_\_\_\_ State License I.D. \_\_\_\_\_

Audiometer:

Manufacturer \_\_\_\_\_ Model \_\_\_\_\_ Serial No. \_\_\_\_\_

Type (manual, automatic, microprocessor) \_\_\_\_\_

(Need to check below if still current)

CALIBRATION (BN. NO. 82-18 requires annual calibration to ANSI 1969 Standards)

Date Calibrated : Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

By Whom \_\_\_\_\_

The audiometric test results are valid and representative of this employee's hearing sensitivity.

Yes  No

If you have reservations concerning the audiometric test findings, please state what additional evaluations or tests you would suggest.

BOTH SIGNATURES ARE REQUIRED. IF THE OPINIONS VARY, PLEASE ATTACH A SIGNED SHEET WITH EXPLICATIVE RATIONALE.

Signature \_\_\_\_\_ Audiologist

Signature \_\_\_\_\_ Physician

Please note the following points which are commonly missed and without which adjudication cannot be completed.

- (1) Please include your complete audiograms with air conduction thresholds between 500 and 8000 Hz. and bone conduction thresholds between 500 and 4000 Hz. Please include impedance audiometry.
- (2) Be sure the audiologist is state licensed, or certified in audiology by the American Speech Language Hearing Association.
- (3) Be sure all opinions are completed and signed by the appropriate individuals.

**V. AUDIOMETRIC TEST RESULTS:**

TO ELIMINATE THE POSSIBILITY OF TEMPORARY THRESHOLD SHIFT, THE PATIENT SHOULD NOT BE TESTED UNLESS FREE OF SIGNIFICANT NOISE EXPOSURE FOR AT LEAST 16 HOURS - OTHERWISE RESCHEDULE. PATIENT FREE FROM NOISE EXPOSURE FOR \_\_\_\_\_ HOURS PRIOR TO TESTING.

Audiometric testing completed on \_\_\_\_\_ at \_\_\_\_\_  
(date) (hour)

Pure-tone Audiometry (please also include your complete audiograms with air conduction threshold from 500 through 8000 Hz; bone conduction from 500 through 4000 Hz; and the tympanogram, acoustic reflexes and/or other impedance testing.) \*

Is a significant air-bone gap present?

	Right - Yes ( )	No ( )		Left - Yes ( )	No ( )
	Right Ear			Left Ear	
	AIR	BONE		AIR	BONE
500 Hz	____ dB	____ dB		____ dB	____ dB
1000 Hz	____ dB	____ dB		____ dB	____ dB
2000 Hz	____ dB	____ dB		____ dB	____ dB
3000 Hz	____ dB	____ dB		____ dB	____ dB
4000 Hz	____ dB	____ dB		____ dB	____ dB
6000 Hz	____ dB			____ dB	
8000 Hz	____ dB			____ dB	

\* The frequency 3000 Hz is required for adjudication in Federal compensation cases.

Was masking (narrow-band) utilized for Pure-Tone Audiometry? Yes \_\_\_\_ No \_\_\_\_ LEVEL: \_\_\_\_ dB

SPEECH AUDIOMETRY	RIGHT	LEFT
Speech Reception Threshold (SRT)	____ dB	____ dB
Auditory Discrimination Scores	____ %	____ %
Discrimination Test given at	____ HL	____ HL

Was masking (wide-band) utilized for speech audiometry? YES \_\_\_\_ NO \_\_\_\_ LEVEL: \_\_\_\_ dB

Do the SRT and PTA (pure tone average) scores agree with 6 dB? YES \_\_\_\_ NO \_\_\_\_

If not, do they agree using the best two frequency "Fletcher" method? YES \_\_\_\_ NO \_\_\_\_

If not, please explain if you believe the discrepancy is of an organic or functional basis and include as much detail as you can?

If there is a marked audiometric discrepancy between each ear, were there particular conditions of exposure or protection that justify this difference? Explain any such difference as fully as possible.

**Public Burden Statement:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not return the requested information to the address shown just above. Rather, send it to the address shown on the letterhead.

**Privacy Act Statement**

The Privacy Act of 1974 as amended (5 U. S.C. 552a) and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.), authorizes collection of this information. The information will be used in conjunction with the Form CA-1331 to refer a claimant for complete audiologic and otologic examination when a claim for hearing loss has been filed. Completion of this form is voluntary, however, failure to provide the information may result in the delay of processing of the claim or payment or benefits, or may result in an unfavorable decision or reduced levels of benefits. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.