UW Speech and Hearing Clinic
UNIVERSITY OF WISCONSIN–MADISON

Goodnight Hall
1975 Willow Drive
Madison, WI 53706
Phone: 608-262-3951
Fax: 608-262-6466

WISHES AMPLIFICATION REQUEST FORM

Date of Request:	
Referring Audiologist Name:	
Business Name:	
Mailing Address:	
Phone:	
Email:	

Child's Name:	
Date of Birth:	
Sex:	☐ Male ☐ Female
Parent/Legal Guardian:	
Mailing Address:	
Phone:	
Email:	

Child's History:

Is this the child's first time using amplification? ☐ Yes ☐ No

What is the degree and configuration of the hearing loss?

Right ear _____

Left ear _____

Does the child use any other amplification? Please describe.

_____

Primary reason for request:

_____

Amplification Requested:

☐ **Behind-the-ear hearing aid/s (please indicate preferences):**

1st Choice:	**Oticon**	**Phonak**
	☐ Sensei Pro SP	☐ Certena M ☐ Certena Micro ☐ Naida UP ☐ Naida SP ☐ Nios Micro III ☐ Bolero Q-50
2nd Choice:	**Oticon**	**Phonak**
	☐ Sensei Pro SP	☐ Certena M ☐ Certena Micro ☐ Naida UP ☐ Naida SP ☐ Nios Micro III ☐ Bolero Q-50

3rd Choice: ☐ **Other**_____

Information will be used for ordering additional amplification devices when funds are available.

☐ **Assistive listening device / FM system:**

☐ **Oticon Amigo** ☐ **Phonak Microlink**

*Audio shoes must be ordered by audiologist and paid for by parent / guardian.

Additional fees paid to audiologist by family:

☐ Fitting fee $_____ ☐ No Charge, Fee Waived

☐ Follow-up visits $_____ ☐ No Charge, Fee Waived

☐ Audio shoes for hearing aids $_____

☐ Other _____ $_____

Audiologist agrees to the following:

- Submit and review all required paperwork to WISHES Program.
- Return amplification to WISHES Program via provided shipping label at the end of the 6 month loan period or submit written request for 3 month extension.
- Submit Parent and Audiologist Satisfaction Surveys.
- Give permission to have their name and / or business information included in a list of participating providers.

Audiologist Signature: _____

Date signed: _____/_____/_____

Required information to submit to WISHES Program:

☐ Amplification Request Form

☐ Parent Use Agreement

☐ Release of Information consent form to the WISHES Program

Please submit all required information to:

Amy Hartman, Au.D.
University of Wisconsin Madison, Department of Communication Sciences and Disorders
1975 Willow Drive., Room 373
Madison, WI 53706
wishes@csd.wisc.edu
608-262-6481