ASCENTIST
Audiology & Vestibular
Center

Tinnitus Management Program

Thank you for your interest in the Ascentist Audiology & Vestibular Center tinnitus program. Enclosed you will find information regarding the program offered. The purpose of this program is to establish an individualized tinnitus management plan designed for your specific needs. It is our belief that tinnitus patients are best served by a comprehensive, multidisciplinary approach. Therefore, in order to ensure that all appropriate diagnostic test procedures have been completed, we request that all tinnitus patients seen in this program have been seen, or are scheduled to be seen, by an otologist or ENT physician. It is important to determine whether your tinnitus is related to a treatable or a systemic condition. In addition, because of the psychological impact of tinnitus, it is possible we will recommend a consultation with a cognitive behavioral health specialist. The behavioral health specialists we recommend will be provided. If you need a referral to an otologist or ENT physician please call Ascentist Healthcare at 816-478-4200.

An audiological evaluation is also required *within the last six months*. If you have not had a hearing test within the last six months, please notify our office so that sufficient time can be scheduled for your appointment.

Please fill out all paperwork included and fax, email or mail them, along with any audiological records, to our clinic. Once we receive your packet of completed forms, they will be reviewed and you will then be contacted to schedule your appointment.

At this appointment we will educate you on current theories of tinnitus as well as treatment and management procedures, including the potential advantages and limitations. It is important to recognize that many of these management procedures are not intended to cure tinnitus. Rather, they are procedures designed to assist you to cope with tinnitus and develop strategies to best adapt to the symptom. Please be aware that success of any tinnitus management approach depends on your interaction and active participation.

Insurance does not cover the cost of tinnitus counseling and management. The cost for the initial visit is approximately $150. Follow-up counseling ranges from $25-$100 per visit. Test procedures associated with the tinnitus counseling appointments, such as hearing tests and tinnitus matching, may be covered by insurance. These are noted on the following page. It is your responsibility to obtain written authorization from your insurance company for the test procedures noted on this page. If your insurance company does not cover any or all of these procedures, or if you have not obtained pre-authorization for each procedure, you will be expected to pay in full at the time of your appointment. These fees do not cover the cost of hearing aids, ear plugs, and/or electronic sound generating devices.

CPT codes that may be required for your first visit: 92625 (tinnitus matching) and 92587 (Otoacoustic Emissions - Limited). If you have not had a hearing evaluation within the last 6 months the CPT codes for that testing are: 92557 (comprehensive audiological evaluation), 92550 (tympanometry and acoustic reflex thresholds).

Hearing aids are not paid by Medicare and may not be covered by insurance. Please let us know if you believe you have an insurance benefit toward devices. Earmolds, ear plugs and sound generators will not be billed to insurance.

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Tinnitus Counseling Appointment Agreement

Please read and complete the following packet of information. **You will be scheduled for a tinnitus counseling appointment once we have received and reviewed the completed paperwork, including this signed patient agreement.** You may mail/fax the paperwork to our clinic.

After reading the attached materials, please initial each of these items below and sign at the bottom.

I understand that:

_____ The purpose of the appointment is to educate me and establish an individualized tinnitus management program and is not intended to result in a cure for my tinnitus.

_____ There is no specific insurance coding for tinnitus counseling. My insurance company will not be billed, and the Audiology Clinic will not accept insurance payment at this appointment.

_____ I will pay for the appointment on the date of service. The initial appointment is typically $150 for the self-pay portion, though it may be greater should other self-pay services be necessary. A portion of the visit will also be billed to the insurance company.

I agree to the terms as noted above and in the Tinnitus Management Program cover letter.

_____

Patient name (please print)

_____ _____

Patient signature Date

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Tinnitus New Patient Intake

_____

Name DOB Age

_____

Today's Date Referred by Phone #

How long have you had tinnitus in its present form? _____

Briefly describe what you were doing when the tinnitus first became apparent to you.

_____

_____

What do you think is the cause of the tinnitus?

_____

_____

Where is your tinnitus primarily located?

- ❑ Left ear
- ❑ Right ear
- ❑ Both ears equally
- ❑ Head
- ❑ Other: _____

The loudness of your tinnitus is (check one):

- ❑ Fairly constant from day to day
- ❑ Fluctuates widely, being very loud some days and very mild other days
- ❑ Usually constant, but occasionally decreases markedly
- ❑ Usually constant, but occasionally increases markedly

Does your tinnitus appear worse (check all that apply):

- ❑ When tired
- ❑ When tense or nervous
- ❑ At bedtime
- ❑ After use of alcohol
- ❑ Upon awakening
- ❑ When relaxed

Circle all items below that describe the sound of your tinnitus:

Hissing	Ringing	Crickets	Whistle
Stream whistle	Pounding	Pulsating	Bells
Clanging	Buzzing	Sizzling	Clicking
Ocean roar	High tension wire	Other_____	

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When are you aware of your tinnitus?_____

What percentage of time are you bothered by your tinnitus? _____

Is there a time of day when your tinnitus is most troublesome to you?

- ❑ At work
- ❑ In the morning
- ❑ In the evening
- ❑ When trying to concentrate
- ❑ At social activities
- ❑ Around noise
- ❑ Other: _____

Have you been exposed to loud noise, either recently or in the past?

- ❑ Yes
- ❑ No

If yes, check all that apply:

- ❑ Machinery/ Equipment
- ❑ Military
- ❑ Music
- ❑ Power tools
- ❑ Firearms
- ❑ Aircraft engines
- ❑ Factory noise
- ❑ Other: _____

Do you wear hearing protection in the presence of loud sounds?

- ❑ Yes
- ❑ No
- ❑ Sometimes

If you are currently utilizing a hearing aid, or have in the past, please answer the following:

Which ear is/was aided?

- ❑ Right
- ❑ Left
- ❑ Both

How does the aid affect your tinnitus?

- ❑ Makes tinnitus softer
- ❑ Makes tinnitus louder
- ❑ No effect

Are you adversely affected by loud sounds?

- ❑ Yes
- ❑ No
- ❑ Please explain if yes: _____
- ❑ _____

Treatment History:
Please list all evaluations and/or treatments (including psychiatric, psychological, MRI, CT scan, etc.) you have had for your tinnitus.

	Provider	What was done?	Visit date	Result
1.				
2.				
3.				
4.				

Please list all medications you are currently taking or have taken for tinnitus:

Medication	Dose	Dose frequency	Does it help?	Doctor

Please list all other medications you currently take:

Medication	Dose	Dose Frequency	Purpose	Doctor

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Lastly, please check all items that are applicable to you:

- ❑ Poor health much of your life
- ❑ History of middle ear disease
- ❑ History of Meniere's disease
- ❑ History of otosclerosis
- ❑ History of facial pain/numbness or paralysis
- ❑ History of labyrinthitis
- ❑ History of mastoiditis
- ❑ History of ear surgery
- ❑ Migraine headaches
- ❑ Hyperventilation syndrome
- ❑ Hypertension (high blood pressure)
- ❑ Cancer
- ❑ Dizziness/ imbalance or vertigo
- ❑ Arthritis
- ❑ Heart disease
- ❑ Increased use of alcohol or drugs
- ❑ Fair to poor dietary habits
- ❑ Moderate to excessive use of caffeine substances (cola, coffee, chocolate)
- ❑ Clenching or grinding teeth
- ❑ Limitation and/or pain with mouth opening or movement side to side
- ❑ History of clicking/locking/popping of the jaw
- ❑ Personal or family history of diabetes/ alcoholism/hypoglycemia (circle)
- ❑ Personal or family history of thyroid or autoimmune disease
- ❑ Personal or family history of hyperlipidemia
- ❑ Personal or family history of inhalant/food allergies
- ❑ History of Epstein-Barr virus, cytomegalovirus, or hepatitis (circle)
- ❑ History of excessive x-ray exposure around the head or neck
- ❑ Lyme disease
- ❑ Low back pain
- ❑ Depression
- ❑ Anxiety
- ❑ Head Injury or Neck Injury

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DATE:

PATIENT NAME:

IOWA TINNITUS PRIMARY FUNCTION QUESTIONNAIRE

Please indiacte your agreement with each statement on a scale from 0 (*completely disagree*) to 100 (*completely agree*). Please do not skip any questions.

1	My tinnitus is annoying.	
2	My tinnitus masks some speech sounds.	
3	When there are lots of things happening at once, my tinnitus interferes with my ability to attend to the most important thing.	
4	My emotional peace is one of the worst effects of my tinnitus.	
5	I have difficulty getting to sleep at night because of my tinnitus.	
6	The effects of tinnitus on my hearing are worse than the effects of my hearing loss.	
7	I feel like my tinnitus makes it difficult for me to concentrate on some tasks.	
8	I am depressed because of my tinnitus.	
9	My tinnitus, not my hearing loss, interferes with my appreciation of music and songs.	
10	I am anxious because of my tinnitus.	
11	I have difficulty focusing my attention on some important tasks because of tinnitus.	
12	I just wish my tinnitus would go away. It is so frustrating.	
13	The difficulty I have sleeping is one of the worst effect of my tinnitus.	
14	In addition to my hearing loss, my tinnitus interferes with my understanding of speech.	
15	My inability to think about something undisturbed is one of the worst effects of my tinnitus.	
16	I am tired during the day because my tinnitus has disrupted my sleep.	
17	One of the worst things about my tinnitus is its effect on my speech understanding, over and above any effect of my hearing loss.	
18	I lie awake at night because of my tinnitus.	
19	I have trouble concentrating while I am reading in a quiet room because of tinnitus.	
20	When I wake up in the night, my tinnitus makes it difficult to get back to sleep.	

TINNITUS HANDICAP INVENTORY

Patient Name: _____ Date: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3. Does your tinnitus make you angry?	Yes	Sometimes	No
4. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16. Does your tinnitus make you upset?	Yes	Sometimes	No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

FOR CLINICIAN USE ONLY

Total Per Column			
	x4	x2	x0
Total Score	+	+	=

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-8.

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐