# WISHES AMPLIFICATION REQUEST FORM

<table>
<thead>
<tr>
<th>Date of Request:</th>
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<tbody>
<tr>
<td>Referring Audiologist Name:</td>
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<tr>
<td>Business Name:</td>
</tr>
<tr>
<td>Mailing Address:</td>
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<tr>
<td>Phone:</td>
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<td>Email:</td>
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| 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
☐ Tego Pro
☐ Tego Power
☐ Vigo Mini
☐ Sumo DM

Phonak
☐ Certena M
☐ Tego Pro
☐ Certena Micro
☐ Vigo Mini
☐ Sumo DM

Siemens
☐ Explorer
☐ Naida SP
☐ Naida UP
☐ Nios Micro III
☐ Bolero Q-50

2nd Choice: Oticon
☐ Tego Pro
☐ Tego Power
☐ Vigo Mini
☐ Sumo DM

Phonak
☐ Certena M
☐ Tego Pro
☐ Certena Micro
☐ Vigo Mini
☐ Sumo DM

Siemens
☐ Explorer
☐ Naida SP
☐ Naida UP
☐ 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