REPUBLIC OF KENYA

MINISTRY OF HEALTH

Ref: MOH/276C

ASSESSMENT FORM FOR HEARING IMPAIRMENTS

Name of Health Facility:		Date:	DD	MM	YYYY

Applicant Information for the purpose of reporting on Disability Assessment:

Name:		ID No.		Gender:	
Date of Birth: Age:	DD / MM / YYYY	Occupation:		Phone No.	
County:		Sub-County:		Marital Status:	

Next of Kin Details:

Name:		Relation:		Phone No.	

Assembled Medical Team details:

MEMBERS	NAME	REG. NO.	SIGNATURE	Health Facility Official Stamp
Chairperson				
Member				
Member				
Member				

(***I understand that giving false information is punishable by the laws of Kenya)***

Note: the committee should have a minimum of three Members

History

History of Hearing Loss	
History of Hearing Devices Usage	

3.0 Hearing Test Results

Hearing Test	Right Ear	Left Ear
Type of Hearing Loss		
Degree (Grade) of Hearing Loss		

4.0 Calculation of Hearing Disability

Ear	Hearing Level in dBHL	Monoaural Percentage of Disability	Overall (Binaural) Percentage of Disability
Right			
Left			

CONCLUSION

TEMPORARY ☐ PERMANENT ☐

RECOMMENDED ASSISTIVE PRODUCT(S)..

OTHER REQUIRED SERVICES...

VERIFIED BY THE COUNTY DIRECTOR OF HEALTH

Name..

Date ....

Signature..

COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP