Standard S1.1 [2025]

Draft Standard

The profession of audiology is committed to providing auditory and vestibular care through ethical and evidence-based clinical practices that lead to optimal patient outcomes. Standard of practice documents outline basic services that audiologists are expected to include in the provision of quality healthcare. They reflect the values and priorities of the profession, providing direction for professional practice and a framework for the evaluation of practice. Standards of practice are prepared by subject matter experts, based on available evidence, peer-reviewed and subject to periodic updating.

AUDIOLOGY GENERAL PATIENT INTAKE STANDARD

1. Patient communication is conducted in a clear, empathetic manner consistent with the patient's comprehension and their health literacy level. [7,13]

2. Information is provided to and collected from the patient, patient's family member, or legal representative using methods required for effective communication (e.g. hand-written, electronic, oral, or signed language). [1]

3. The patient is encouraged to include communication partners (e.g., family members, significant others, companions, interpreters) throughout the visit. [4]

4. During intake, information that is collected may include:

    a. Demographic and contact information.

    b. Legal and financial documents. This may include consent to treat, insurance, advance beneficiary notice, good faith estimate, HIPAA notice, release of medical information, prior authorization, or medical referral, as required.

    c. Chief complaint, history of present illness, and current symptoms including functional impact of hearing or balance deficit.

    d. Information related to medical and surgical history (including comorbidities), current medications, allergies, medical/specialist team members, and developmental concerns.

    e. Indications of ear disease which may require medical referral. These may include unilateral or sudden onset hearing loss, physical deformities of the outer ear, drainage,

pain, or discomfort of the ear, unilateral or pulsatile tinnitus, dizziness, vertigo, or loss of balance. [3,6]

f. Social history, which may include marital status, sexual orientation and gender identity, employment history, recreational history of alcohol, drug, and tobacco use and environmental factors such as noise exposure history (military, occupational and recreational). [2]

g. History of tinnitus, including the nature, onset, and impact on patient's quality of life. [3,5]

h. Indicators of fall risk. [10,14,16]

i. Audiologic history (e.g. previous hearing examinations, hearing amplification devices) as available. [2]

5. Specialized questionnaires are completed if relevant to appointment type. These often include measures of hearing handicap, tinnitus distress, mental health, and cognitive screenings.[8,9,11,12,15,16,17]

6. Following collection of information, the audiologist determines the plan for evaluation.

7. Additional information continues to be collected throughout the course of the initial appointment and subsequent visits. This is reviewed periodically.

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