## REPORT OF LOSS OR DAMAGE TO HEARING AID

**NAME**………………………………………………… **DATE OF BIRTH**…………………………..

**ADDRESS**………………………………………………………………………………………………..…

………………………………………………………………………………………………………………..

**CONTACT NUMBER: LANDLINE** ………………………M**OBILE** .…………………..…………

**HEARING AID DETAILS - ADVISE BELOW IF LEFT, RIGHT OR BOTH**

………………………………………………………………………………........................................

**DATE OF ISSUE**……………………………………………………………………………………….…

**CIRCUMSTANCES OF LOSS OR DAMAGE (failure to complete this section will result in**

**the form being returned to you)**

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…………………………………………………………………………………………………..

**DATE OF LOSS**……………………………………………………….……………………………………

**IF YOU HAVE LOST THE EAR MOULD, PLEASE POST IN BLUE IMPRESSION OR MAKE AN APPOINTMENT BY PHONING 08009178056 (IF YOU DO NOT HAVE A FULL EAR MOULD AND HAVE AN OPEN FIT (WITHTUBES/DOMES) THEN THIS WON’T APPLY TO YOU).**

Once completed, please return this form to the address below:

**Audiology Department, Raigmore Hospital, Old Perth Road, Inverness, IV2 3UJ**

### PLEASE NOTE

All hearing aids remain the property of NHS HIGHLAND.

You will be liable to a charge towards the administration costs of replacing your aid. The current charge is £40 (subject to review). In the event of any damage to your aid this charge will be £40 towards the cost of repair.

**You will receive an invoice from the finance Department. This must be paid in full before the aid will be issued. DO NOT SEND PAYMENT WITH THIS FORM**

The invoice must be paid prior to reissue of the aid. Current wait times are approx. 8/10 weeks.

**SIGNED** …………………………………………………………………………..

**DATE** …………………………………………………………………………..