1. Introduction and Who Guideline applies to

The following are guidelines to be used by Paediatric Audiologists when reviewing a child; up to the age of 15 years, with a hearing aid/s. This includes AC and BC aids but excludes surgically implanted devices, BI/CROS aids or children aged >=15years who have entered the transition to Adult Service program (See specific guidelines for these).

It is expected that the Audiologist will use this as a guide only and that the Audiologist's discretion will be used when applying these guidelines to ensure that the review appointment validates the hearing aid fitting but also accommodates the individual requirements of the family and child. These local guidelines should be used in conjunction with relevant national guidelines (See References).

It is expected that Audiologists using this guideline will be competent with hearing aid software, programming and REM equipment & set up. New starters will have had supervised training and been assessed as to their competency.

Children attending a hearing aid review appointment will either have had a hearing aid/s fitted at the previous appointment (1st review) or may be a longer term hearing aid/s wearer. The hearing aid/s may be being used as habilitation of a temporary or permanent hearing loss.

The purpose of the review is to validate the hearing aid/s fitting (1st review) and to check stability of hearing, verify/validate hearing aid/s programming, update hearing aid/s, check use of aid/s and discuss how the child is managing, identify and address issues, provide ongoing awareness and training regarding hearing loss, hearing aids, hearing aid maintenance and wireless technology.

The audiologist needs to review the child's needs holistically and recognise that needs and priorities may change as the child gets older, particularly during adolescent when aesthetics, peer pressures and self-confidence/esteem may become particularly important for the child.

2. Guideline Standards and Procedures

Appointments

- A child's review appointment being due will have been identified from the Paediatric Hearing Aid spreadsheet and booked accordingly

Pre appointment checks

- Read patient notes from PN and reports from TOD or other professionals
- Speak to TOD; if attending appointment, prior to seeing child to obtain up to date information
- Plan session
- Calibrate / check equipment (See Departmental stage A calibration guideline (BSA, 2018a)) and set up room appropriately
- Ensure all appropriate equipment available e.g. speech test
- Check that hand gel and anti-bacterial wipes are available

- Check whether an interpreter is booked and has arrived (If applicable).

Introduction

- Invite all attending adults and children into the clinic room
- Introduce all persons in the room
- Check the relationship to the child of accompanying adults and; if not parents, has consent been obtained from the parent to bring the child to the appointment.
- Check that all addresses and details on PN are correct
- Are there any other professionals involved in child's care, if so, what is there involvement and would they benefit from a copy of the review report? Full addresses will be required
- Explain the purpose of the appointment and how it will proceed. Obtain verbal consent to proceed.

History

The history taken will vary depending on the age of the child, how long they have had the aid/s and previous history/issues. The history table on the hearing aid report template can be used as a guide;

- Depending on the age of the child, try to ask the child for their opinion prior to asking parents. This helps when determining child's attitude towards the hearing aid/s and prevents the child's answer being influenced by the parents
- Use of aid at home, school and socially?
- Check whether aid worn all waking hours or more selectively – Check and record data logging from aid/s
- Check whether aid/s worn at weekends/school holidays
- Any problems with aid/s?
- Any problems with ears? For example, infections
- Any fluctuations/changes in hearing?
- Is the aid/s beneficial – What do parents, child teachers etc. perceive?
- How is the child developing/managing in general e.g. speech, understanding, academically, behaviourally, general communication/interactions?
- How child/parent is managing the aid/s, including inserting aid/s, changing batteries, cleaning and general maintenance?
- Does child/parent know how to retube their earmould/s, change filters and problem solve faults? – Demonstrate these or make a note if these are to be discussed at a future appointment
- Have child/parents got any questions or concerns that they need addressing during the review apt?

Testing

Which tests are performed is at the Audiologist's discretion based on prioritising of information. The purpose of testing is to check for any changes of hearing threshold, obtain

additional hearing threshold information and to enable hearing aid/s to be reprogrammed optimally. The following questions should be considered when prioritising the testing required;

- Behavioural age of the child i.e. which tests are possible?
- Is the child not wearing the aid/s or is there concern regarding child/parent acceptance of the hearing loss or need for the hearing aid/s? Consider aided vs unaided testing to demonstrate benefit
- Is a full audiogram available (AC, BC, ear specific and reliable at minimum frequencies 0.5, 1, 2 and 4KHz)? If not, consider checking thresholds and filling in the gaps
- Is the hearing stable and tested within the last 12 months? Hearing should be checked (Minimum) annually in primary school age children with stable hearing and twice yearly in senior school age children with stable hearing. More frequent testing is required for preschool children and those with fluctuating or deteriorating hearing. Any reported possible improvement/deterioration in hearing during history taking should result in the hearing being checked
- Has the child/parent history or TOD report created any questions that need answering? Consider tests that could help to answer these
- What test information has been obtained at previous appointments? Fill in the gaps

The following tests should be considered. They are in order of priority but will not all be repeated at each appointment e.g. If hearing thresholds and REM were accurately established at the previous appointment, ling and speech discrimination may be prioritised at the next appointment

1. Hearing thresholds. AC/BC, ear specific 0.5-4KHz minimum
2. Measured RECD/in situ REM
3. Aided Ling sounds. Binaurally as a minimum but each aid individually ideally
4. Aided Speech discrimination
5. Aided vs unaided sound field warble tones – this is to demonstrate hearing aid/s benefit as it provides minimal information that can be used to optimise hearing aid/s programming and does not reflect the sound processing that the aid/s does to optimise hearing

For further information regarding Ling and speech discrimination testing, see Speech Testing guidelines.

- Check that aid is working via a stetoclip or electro acoustically. If a 2nd Audiologist/TOD is available then they can do this whilst the history is being taken
- Check the aid for signs of wear and tear and replace parts as required e.g. tamperproof battery drawers, filters etc. Check that the battery lock is being used if appropriate (Mandatory for all children aged <=4yr olds).
- Re-tube the ear moulds if they are to be used for ear specific testing as a tiny amount of condensation can cause a significant elevation in thresholds and may not have been visible to the eye
- If measured RECD is likely to be performed (As opposed to in situ REM) threshold testing must be performed using inserts (Attached to foam tips or ear moulds)
- Ensure ear specific AC and BC thresholds available for as many frequencies 0.25-8KHz as possible

- Accurate and masked thresholds at fewer frequencies are more important than obtaining all frequencies e.g. 0.5 + 2KHz, rt + lt, AC + BC
- Testing can be attempted on babies from 5 months corrected age but warn parents prior to testing that if their child doesn't respond then it may be due to their age rather than their hearing.
- Compare all available test results to check for consistency of diagnosis and note fluctuations due to middle ear effusion
- Tympanometry to be completed at each appointment to monitor middle ear function in order to confirm diagnosis and provide information for RECD/REM (1KHz tymp for babies <6 months)
- REM/RECD should be performed and hearing aid/s reprogrammed; as follows, due to changes in threshold, middle ear function, change of ear mould acoustics or growth of ear canal. This should be measured; as opposed to predicted, whenever possible.

1. Every 3 months 0-12months old
2. Every 6 months 12months-2yrs old
3. Annually 2yrs+ old

- Consideration should be given to doing additional REM/RECD if a different style of ear mould is issued or there is a change in middle ear status
- If a measured RECD has been done within the time frames above then, if the Audiologist considers that it is unlikely that the ear canal volume has changed significantly, this can be used to reprogram an aid/s if thresholds change in between times
- If definitive hearing thresholds can't be established via behavioural hearing tests, ABR GA referral should be discussed as accurate thresholds are needed to ensure optimally aided

Alterations to hearing aids

- At each appointment the audiologist should review all information to consider whether the current hearing aid/s is still most appropriate for the child. If other options are appropriate, these should be discussed with the child/family. Examples below;

    1. Problems with BC aid – discuss AC aid or grommet options
    2. Problems with AC aids - discuss BC aid or grommet options
    3. BC aid issues but AC aid/grommets not appropriate, consider reviewing in BAHA clinic for alternative surgical or non-surgical options to be considered
    4. AC aid issues and long term hearing loss with BC thresholds better than 70Dbhl. Consider reviewing in BAHA clinic for alternative surgical or non-surgical options to be discussed
    5. BC aid wearer aged >=4 years with a permanent hearing loss (Or highly unlikely to regain normal hearing) but AC aid/grommets not appropriate, consider reviewing in BAHA clinic for BAHI implant to be considered
    6. Use of slim tube/dome rather than ear mould
    7. Referral for Cochlear Implant (CI) assessment should be actively encouraged if hearing thresholds are within CI criteria. Emphasis when discussing referral should be that the referral doesn't mean that they will have to have surgery, but they will learn a lot more about what their child can and can't hear during the assessment process

AC aids

- Discuss need for tamper proofing battery drawer ensuring that consideration is given to family members and risks to other family members, visitors and peers. If a lockable battery drawer waiver form is not on PN, ensure this is completed if relevant
- Routine re-programming of hearing aid/s due to growth of the ear canal should be done as per the REM/RECD guide above
- For babies or children unable to perform behavioural testing, hearing aid/s should be reprogrammed using measured RECD or age appropriate predicted RECD and an estimated audiogram based on known/inferred information from past testing and history taking
- Children with ANSD should have hearing aid/s adjusted based on behavioural test results. If these aren't available then emphasis should be given to parental and TOD reports i.e. if no behavioural results are available and hearing aids are programmed to a 70 or 90dBHL estimated loss, if parents report no loudness discomfort and limited response to sound, increase the estimated audiogram by 20dBHL and re-programme to targets. Check for loudness discomfort post programming.
- If hearing thresholds have changed then reprogramming the hearing aid/s should be considered. Consideration may be given as to reliability of new thresholds, likelihood of hearing returning to its original level in short term, history of degree of fluctuation previously, whether the volume control is activated and loudness discomfort issues.
- Hearing aid/s should be reprogrammed if test results e.g. speech discrimination scores, indicate that hearing may be improved or if subjective reports indicate that adjustments may be beneficial
- Alterations to the hearing aid should be performed via in situ REM/measured RECD or predicted RECD should be used if measurement is not possible. See hearing aid fitting guidelines for further information regarding this.
- Ideally measured RECD should be re-measured prior to each re-programming. A previous measured RECD can be reused if it is not possible to re-measure or at the Audiologist's discretion e.g. temporary change in middle ear status or if a recent measured response is available. If using a previously measured RECD, the date that the measurement was taken should be noted in the RECD notes box in REM software and also on the hearing aid report
- If a conductive element to the hearing loss is suspected or measured, BC values should be plotted onto the audiogram for the aided ear/s so that these are taken into account by the software when calculating a target. If all necessary BC thresholds have not been measured at the review appointment but a new measured AC audiogram has been created, add the BC thresholds to a separate new audiogram i.e. do not add estimated thresholds to an audiogram with measured thresholds. Save the audiogram with the estimated thresholds as 'BC values estimated for programming'.
- When reprogramming hearing aid/s the Audiologist needs to consider any post programming adjustments previously made e.g if aids are intentionally programmed above or below target or frequency lowering strengthened or weakened due to child preference or previous validation results i.e. prescribed targets are to be used as a starting point for programming but they do not account for individual listening needs of the child
- Activation of volume control, mute function or additional programs should be considered and discussed if there may be benefit of these for the child

- If a child is concerned about the wearing of their hearing aid for cosmetic reasons, more cosmetically acceptable options should be discussed if appropriate e.g. open fit, change of colour of aid/s/ear mould/s. The pros and cons of alternatives should be clearly explained, in terms of hearing (ability to match target), ability of the child to insert the tube/dome correctly and retention in the ear. Open fit aids are not recommended for young children (<=8yrs) for the above reasons and the child needs to be able to cooperate for in situ REM. Counselling regarding self-esteem, positive attitudes, TOD support regarding awareness of peers etc. should be done as well as consideration of hearing aid alteration
- CIC aids are not recommended for young children (<=11yrs) due to retention issues and should only be offered if the child continues to have significant cosmetic concerns despite all other options being tried and counselling and support in clinic and via the TOD having been given. Refer for a CIC trial on outcome form if appropriate

BC aids

- Discuss use of tamper proofing battery drawer/s ensuring that consideration is given to family members and risks to other family members, visitors and peers
- Perform BC direct if not done previously, within the last 12 months or if a different style of headband is used
- If the child is wearing a unilateral aid consistently and behind the ear, consider fitting a binaural device if appropriate
- If aid is being worn consistently a spare soft band can be issued

Discussion

- Summarise what has been done, results of tests and any uncertainties/missing information
- Ask parents and child opinion on what has been done and answer any questions
- Discuss and agree action plan and aims for parent/child e.g. increase numbers of hours worn
- Discuss and agree actions for Audiologist e.g. referral to ENT, referral for CI, referral for ABR GA
- Discuss testing/outcome priority of next appointment and agree timing of next appointment. Offer parents a choice of venue and ensure any specified parents or Audiologist specific requests for the next appointment are noted on the outcome form
- If the hearing aid/s is no longer required, it should be returned to the Audiologist and the child discharged from the hearing aid service on the outcome sheet, the patient may keep the ear moulds.
  Agree with the parents whether any further hearing tests are required and, if so, either add to appropriate pending list or refer to the Community Audiology service for future monitoring. All Down syndrome children should automatically be referred to community audiology for review as per their review policy. 'Bank' children (PCHI who don't wear hearing aids) should be reviewed on HSD diagnostic clinic until hearing thresholds established and referred to community audiology if completed.

Reviews (At the Audiologist's discretion dependent on aid type, loss, concerns and hearing aid experience)

- Discharge from Hearing Aid Service if aid/s no longer required, see above

- Every 3 months for age range 0-18 months
- Every 6 months for age range 18 months-3 yrs (If reliable, stable behavioural responses have been established and audiologist, parent and TOD are happy with hearing aid use and progress)
- Annually 3yrs+ (If reliable, stable behavioural responses have been established and audiologist, parent and TOD are happy with hearing aid use and progress)
- More frequent reviews may be necessary at the Audiologist's discretion, particularly if hearing fluctuates or is deteriorating, or accurate thresholds and hearing aid validation aren't complete
- Children wearing BC aids may be reviewed less frequently as fluctuations in hearing do not require reprogramming of the hearing aid
- Consider whether a 1T, 1.5T or 2T apt is required based on the likelihood of the child being cooperative for testing when reviewed
- All BC aid reviews will be 45 minutes as REM and aid alterations are minimal
- All AC aid reviews will be 1.5 hours unless specified by the Audiologist
- 1T/2T BAHA clinics are only for consideration of alternative non-surgical BC aids (SoundArc, Adhear, spectacle BC) or surgical BC or Middle Ear Implant options – speak to the paediatric BAHI lead if more information required
- CIC and BAHA clinics are at LRI only.

  1T clinics are at all venues

  1.5T clinics (Need 2 testers but not VRA and are at all venues except Two Steeples Medical Practice)

  2T clinics are at LRI, Hinckley and Coalville (Comet Way).

Documentation

- Ensure that all information, options discussed and management plan are clearly recorded and legible if someone else sees the child – use PN note templates
- Alter hearing aid/s/mould/s card if any changes made to type of aid/s/mould/s
- If a lockable battery drawer waiver has been signed, put for scanning by Paed admin
- Report with test results, changes made to aid/s/mould/s, summary of discussion and management plan to be written to parents and copied to TOD, school, GP and any other appropriate professionals
- Ensure that aid/s, mould/s and programming details are completed and accurate on report form
- Add new/replacement (not BAHI) hearing aids to PN devices
- If a new BAHI (not SXU) is issued, put details onto BAHA fitting spreadsheet (H drive/BAHA/BAHI orders and fittings/BAHI fittings)
- Print report copies (If at LRI), including a copy to be emailed to TOD.
- Send email report copies (Except TOD)
- Complete outcome sheet. Ensure that venue for review and any patient specific appointment requirements are asked and noted.

  At outreach sites, add onto outcome sheet how many copies are required to be printed by Admin and email this to paediatricHSD@uhl-tr.nhs.uk

- Place collated reports and outcome sheets in the paediatric hearing aid admin 'reports in' tray in the Admin office at LRI
- Complete medical referral and consultation on PN
- Ensure patient is attended on PN

3. Education and Training

No training is required for current staff.

New staff to the department or to the paediatric team will require a period of supervision dependent on their experience and skill level. The peer review process will be undertaken before they are able to work unsupervised.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Room prepared appropriately and plan for appointment prepared	Peer review process	Head of Paediatric Audiology	New starter after initial supervisory period. All applicable paediatric staff every 2 years	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Introduction of adults present and demographic details checked as appropriate	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Appropriate history taken	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Appropriate tests performed to address concerns, ensure optimum aiding and make best use of appointment time available	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Appropriate adjustments made to hearing aids with informed consent from parents	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented

Appropriate discussion/explanation of results and alterations based on the child's needs or concerns identified	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Action plan agreed with child/family	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented
Documentation complete	Peer review process	Head of Paediatric Audiology	As above	Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented

5. Supporting References

1. British Society of Audiology (2018) *Practice Guidance Verification using probe microphone measurements*
2. British Society of Audiology (2018a) *British Society of Audiology recommended procedures* – Pure tone and air conduction and bone conduction threshold audiometry with and without masking.
3. British Society of Audiology (2021) *Practice Guidance Early Audiological Assessment and Management of Babies Referred from the Newborn Hearing Screening Programme*
4. British Society of Audiology (2023) *Position Statement and Practice Guidance Audiological assessment and hearing aid provision for patients with a programmable ventriculo-peritoneal (PVP) shunt*
5. Feirn, R. (editor). (2014). *Guidelines for Fitting Hearing Aids to Young Infants. version.*Available:http://research.bmh.manchester.ac.uk/mchas/innfantHAfittingguidelines/infantHAfittingguidelines.pdf. Last accessed 19/1/2018.

Title of P&G Document Being Reviewed: Insert Details Below:		Yes / No / Unsure	Comments
1.	**Title and Format**		
	Is the title clear and unambiguous?		
	Does the document follow UHL template format? *If no document will be returned to author*		
2.	**Consultation and Endorsement**		
	Complete the consultation section below		
3.	**Dissemination and Implementation**		
	Complete the dissemination plan below		
	Have all implementation issues been addressed?		
4.	**Process to Monitor Compliance**		
	Ensure that the Monitoring Table has been properly completed.		
5.	**Document Control, Archiving and Review**		
	Ensure that the review date and P/G Leadis identified.		
6.	**Overall Responsibility for the Document**		
	Ensure that the Board Director Lead is identified		

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) **Sheena Hartland** **Head of Paediatric Audiology**	**Executive Lead** **Elizabeth Morgan-Jones** **Head of Hearing Services**
Details of Changes made during review: duplication paragraph deleted from documentation section v1.1. **Correction of REM frequency guidelines as age 6-12 months missing v 1.2.** **Clarification of diagnostic follow up arrangements for bank children pre-school and school age v 1.3** **Alteration of review frequency from 5yrs+ to 4yrs+ v 1.4** **Addition of appendix regarding PVP shunt v1.5** **Addition of advice regarding adding and using BC values when programming hearing aid v1.6** **version 1.6** **Change of advice for tamper proofing from <=3yrs to <=4yrs and additional guidance regarding checking tamper proofing is being used and is not faulty version 1.7** **Addition of reference to departmental stage A calibration guidelines to pre appointment checks section on page 1 version 1.8** **Version 2** **Removal of PVP shunt appendix** **1.5T clinic type added** **Programing and REM changes of procedure made to reflect current aids and Affinity set up** **General changes to procedure to reflect current practice**	

6. Key Words

Hearing aid; Hearing Test; Paediatric Audiology; Hearing Services; Hearing; Audiology

1. OVERVIEW

2. EQUALITY IMPACT ASSESSMENT

		Comments	
1.	**What is the purpose of the proposal/ Policy**	To standardise practice for paediatric hearing aid reviews	
2.	**Could the proposal be of public concern?**	No	
3.	**Who is intended to benefit from the proposal and in what way?**	Audiologists as it provides guidance for the review of children with hearing aids and patients/family as it provides standardisation of practice	
4.	**What outcomes are wanted for the proposal?**	Standardised hearing aid management advice and considerations for paediatric hearing aid review appointments	
		Yes/No	**Comments**
5.	**Is there a possibility that the outcomes may affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and transsexual people	No	
	Age	Yes	Guidelines are for children <16 years old
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
6.	Is there any evidence that some groups are affected differently?	No	
7.	If you have identified that some groups may be affected differently is the impact justified E.g. by Legislation: National guidelines that require the Trust to have a policy, or to change its practice.	n/a	

		Comments	
8.	Is the impact of the proposal / policy likely to be negative?	No	
9.	If so can the impact be avoided?	n/a	
10.	What alternatives are there to achieving the proposal/ policy without the impact?	n/a	
11.	Can we reduce the impact by taking different action?	n/a	

If you have identified a potential discriminatory impact; please ensure that you do a Full Impact Assessment.

If you require further advice please contact Service Equality Manager on 0116 2584382.

3. CONSULTATION SECTION

(To be completed and attached to Policy and Guidance documents when submitted to the UHL Policy& Guidelines Committee)

Elements of the Policy or Guidance Document to be considered (this could be at either CMG/Directorate or corporate level or both)	**Implica-tions** (Yes/ No)	**Local or Corpor-ate**	**Consul-ted** (Yes/ No)	**Agree with P/G content** (Yes/No)	**Any Issues** (Yes / No)	**Comments / Plans to Address**
Education (ie training implications)	No					
Corporate & Legal	No					
IM&T (ie IT requirements)	No					
Clinical Effectiveness	No					
Patient Safety	No					
Human Resources	No					
Operations (ie operational implications)	No					
Facilities (ie environmental implications)	No					
Finance (ie cost implications)	No					
Staff Side/ (where applicable)	No					
Any others	No					

Committee or Group (eg CMG/Directorate Board) that has formally reviewed the Policy or Guidance document	**Date reviewed**	**Outcome / Decision**
MSS	17/11/23	Approved

Lead Officer(s) (Name and Job Title)	**Contact Details**
Hazel Busby-Earle (Consultant)	hazel.busby-earle@uhl-tr.nhs.uk

Please advise of other policies or guidelines that cover the same topic area:

Title of Policy or Guideline:
See References.

4. IMPLEMENTATION AND REVIEW

Please advise how any implications around implementation have been addressed:	
Financial	N/a
Training	N/a

REVIEW OF PREVIOUS P&G DOCUMENT		
Previous P&G already being used? Yes		**Trust Ref No: n/a**
If yes, Title: Paediatric Hearing Aid Review. Clinical guideline v1.		
Changes made to P&G? Yes	**If yes, are these explicit** Yes **If no, is P&G still 'fit for purpose?** Yes	
Supporting Evidence Reviewed? Yes	**Supporting Evidence still current?** Yes	

5. DISSEMINATION PLAN

DISSEMINATION PLAN			
Date Finalised:	**Dissemination Lead (Name and contact details)** **Sheena Hartland, Head of Paediatric Audiology** **Sheena.hartland@uhl-tr.nhs.uk**		
To be disseminated to:	**How will be disseminated, who will do and when?**	**Paper or Electronic?**	**Comments**
Paediatric HSD Staff	**Staff meeting/shared drive**	**Electronic**	**n/a**

CATEGORY 'C' POLICIES OR GUIDELINES ONLY CMG/Directorate Approval Process:	
CMG Approval Committee:	MSS
Date of Approval:	17/11/23
Copy of Approval Committee Minute to be submitted with request to upload into Policy and Guideline Library	

Glossary of terms

1T	-	One tester
2T	-	Two tester
ABR	-	Auditory Brainstem Response
AC	-	Air conduction
ANSD	-	Auditory Neuropathy Spectrum Disorder
Apt	-	Appointment
BAHA	-	Bone Anchored Hearing Aid
BAHI	-	Bone Anchored Hearing Implant
BC	-	Bone conduction
CIC	-	Completely in the Canal
ENT	-	Ear, Nose and Throat
GA	-	General Anaesthetic
GP	-	General Practitioner
HSD	-	Hearing Services Department
LRI	-	Leicester Royal Infirmary
LT	-	Left
PCHI	-	Permanent Childhood Hearing Impairment
PN	-	Practice Navigator
RECD	-	Real ear to coupler difference
REM	-	Real ear measurement
Rt	-	Right
SXU	-	Ex-user stock
TOD	-	Teacher of the Deaf
TYMP	-	Tympanometry/Tympanometer
Yr	-	Year