Our Ref: { MERGEFIELD MATTER_FEE_EARNER_ID }/{ MERGEFIELD client_no }/{ MERGEFIELD matter_no }

Date: { SET LETTER{ DATE \@ "d MMMM yyyy" } }{ref LETTER \@ "d MMMM yyyy" \ * MERGEFORMAT }

DEAFNESS INTERVIEW QUESTIONNAIRE

Name	{ MERGEFIELD "LINKNAME_TITLE_1" } { MERGEFIELD "LINKNAME_INITIALS_1" } { MERGEFIELD "LINKNAME_SURNAME_1" }
Address	{ MERGEFIELD "CLIENT_HOUSE" } { IF { MERGEFIELD CLIENT_AREA }= "" "" "{ MERGEFIELD CLIENT_AREA } " }{ MERGEFIELD "CLIENT_POSTAL_TOWN" } { IF { MERGEFIELD CLIENT_COUNTY }= "" "" "{ MERGEFIELD CLIENT_COUNTY } " }{ MERGEFIELD "CLIENT_POSTCODE" }
Date of Birth	{ MERGEFIELD TK_PICLIENTINFO_tkCL_DOB }
Telephone	{ MERGEFIELD CALCULATION_PHONE }
Your National Insurance Number	{ MERGEFIELD TK_PICLIENTINFO_tkNINUMBER }
Marital Status	
Name Of Next Of Kin If Under 18	
Income Support?	
DSS Office	
Any other benefits?	
Name of GP	
Address	
GP Referral for hearing problems? When?	
Hospital referral for hearing problems?	
If YES, Name of Consultant (If known)	
Name and address of Hospital	
Details of Referral(s)	
Hearing tested by any of your former employers?	
If Yes, (1) Date(s) of test(s)	
(2) Results (related to NIHL?)	

Any other hearing tests?	
How easily can you hear a two-way conversation?	
Do you have to Concentrate &/or lip read?	
Can you hear:	
(1) Doorbell	
(2) Telephone	
(3) TV	
(4) Radio/Hi-fi	
(5) Traffic	

How easily can you hear when you are in a group of people?
(When subjected to background noise)

Do you suffer from the condition Tinnitus? (Ringing/Buzzing Noises)

If YES:	
(1) How often does is occur?	
(2) How long does it last?	
(3) Does it disturb your sleep?	
(4) How would you describe it MILD/MODERATE/SEVERE	

How does your hearing problem affect your daily life?

Have you ever claimed any DSS Benefits for Industrial Injury, e.g. Deafness/Asthma?

Have you previously sought legal advice about your problem?
YES/NO

If YES:

A) On what date

B) Name of Advisor

C) Address

Work History since leaving school (Complete attached sheet)

I certify that the above information is true to the best of my knowledge and belief.

Signed .....

Dated .....

I { MERGEFIELD "LINKNAME_FORENAME_1" } { MERGEFIELD "LINKNAME_SURNAME_1" } of { MERGEFIELD "CLIENT_HOUSE" }, { IF { MERGEFIELD CLIENT_AREA }= "" "" "{ MERGEFIELD CLIENT_AREA }, " }{ MERGEFIELD "CLIENT_POSTAL_TOWN" }, { IF { MERGEFIELD CLIENT_COUNTY }= "" "" "{ MERGEFIELD CLIENT_COUNTY }, " }{ MERGEFIELD "CLIENT_POSTCODE" } hereby confirm that the information given in the Accident Questionnaire is true.

Signed .....

Dated.....

NAME OF COMPANY	ADDRESS	DATES WORKED		HOURS IN WORK NOISE		OCCUPATION	EAR PROTECTION
		STARTED	FINISHED	HOURS	SHIFT		