UCSF Medical Center
COCHLEAR IMPLANT CENTER

2380 Sutter Street, First Floor, San Francisco, CA 94115-0342
Voice: (415) 353-2464, (415) 885-3889 (V/TDD); Fax: (415) 353-2672
Email: CochlearImplant@ucsf.edu

REQUEST TO TRANSFER POST-IMPLANT CI CARE TO UCSF

Name: _____ Tel (H): ( ) _____-_____

Address: _____ Tel (C): ( ) _____-_____

_____ Email:_____

D.O.B. _____/_____/_____ SSN: _____-____-_____

Cause of Deafness: _____ Years of Deafness Prior to CI: _____

Ear Implanted: ❒ Right ❒ Left Years of Hearing Aid Use Prior to CI: _____

Name of Facility that Performed CI Surgery: _____

Name of Implanting Surgeon: _____

Date(s) of CI Surgery(ies): _____/_____/_____ and _____/_____/_____

Date(s) of Initial Stimulation: ____/____/____ and _____/_____/_____

Name of Most Recent Center Providing CI Care: _____

Name of Current Audiologist: _____

Phone # of Most Recent CI Center Used: ( ) _____-_____

Is there currently a problem with your device/equipment? Yes / No

If yes, please describe:-

_____

_____

Reason for Requesting Transfer to UCSF:

_____

_____

_____

Device Manufacturer: ❒ Advanced Bionics Corporation ❒ Cochlear Americas ❒ MED-EL

Device Model/s (check all that apply):

❒ S-Series Body Processor
❒ PSP Body Processor
❒ Platinum BTE
❒ CII BTE
❒ Auria
❒ Harmony
❒ Neptune
❒ SPrint Body Processor
❒ Esprit N22
❒ 3G for N22
❒ 3G for N24
❒ Freedom
❒ Nucleus 5
❒ TEMPO+
❒ Opus I
❒ Opus II

Please complete this form and return to the UCSF Cochlear Implant Center by email, fax or mail. You will be contacted with the outcome of our Team's review of your request.