access to hearing aid technology and consumer hearing products, especially for people with mild to moderate hearing loss. (For ASHA’s response to the report, go to on.asha.org/asha-pcast-response.)

And it’s important to note that the USPSTF’s “I” rating does not apply to those seeking evaluation for perceived hearing problems. The USPSTF recommends that symptomatic adults have their hearing assessed objectively and treated when indicated.

The PCAST and USPSTF recommendations underscore the need for us to disseminate messages about the evidence-based efficacy of hearing health care interventions. Hearing aids reduce caregiver burden, reduce depressive symptoms and boost social engagement—factors critical to positive health outcomes and quality of life. Aural rehabilitation reduces self-perceived psychosocial hearing difficulties.

Should a physician ask you about referral guidelines, I suggest recommending that they refer patients to you who:

• Rate their hearing quality as poor.
• Experience pressure from family members to seek help.
• Are willing to try hearing aids.
• Self-perceive the psychosocial impact of hearing loss.
• Are depressed, feeling lonely or have fallen within the past month—all risk factors for untreated hearing loss.

It is also helpful if audiologists go well beyond the audiogram in communicating with patients and referring physicians, sharing information about diagnosis and treatment outcomes, perhaps in the form of a Hearing Loss Prescription as shown in the accompanying graphic. Relating our patients’ everyday experiences and social lives to hearing aid use is the road less traveled, but it is the fork well worth taking.

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