



**Sri Lakshmi Narayana Institute of Medical Sciences**

Date 02/07/2020

From  
Dr.K.R.Jothikumar,  
Professor and Head,  
otorhinolaryngology,  
SLIMS  
Bharath Institute of Higher Education and Research,  
Puducherry.

To  
The Dean,  
SLIMS  
Bharath Institute of Higher Education and Research,  
Puducherry.

**Sub: Permission to conduct value-added course: :Audiological Rehabilitation reg.**

Dear Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: Audiological Rehabilitation on July 2020 to Dec 2020. We solicit your kind permission for the same.  
Kind Regards

Dr.K.R. Jothikumar

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**FOR THE USE OF DEANS OFFICE**


Names of Committee members for evaluating the course:

The Dean:

The HOD:

The Expert:

The committee has discussed about the course and is approved.

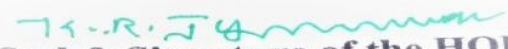
Dean 

(Sign&Seal)

**DEAN**  
Prof.K.BALAGURUNATHAN,M.S  
(General surgeon)  
SRI LAKSHMI NARAYANA  
INSTITUTE OF MEDICAL SCIENCES  
OSUDU PONDICHERRY

  
Dr. R. VENKATARAMAN, MS.  
Reg. No: 72549  
Professor ENT  
Sri Lakshmi Narayana Institute of Medical Sciences  
Osudu, Kudapakkam, Puducherry-605 502

subject expert  
(Sign & Seal)

  
**Seal & Signature of the HOD**  
**PROFESSOR & HOD**  
**DEPARTMENT OF E.N.T**  
Sri Lakshmi Narayana Institute Of Medical Sciences  
PONDICHERRY - 605 502



OFFICE OF THE DEAN

## Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,  
PUDUCHERRY - 605 502.

[ Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME ( P -II ) dt. 11/07/2011 ]  
[ Affiliated to Bharath University, Chennai - TN ]

**Ref. No. SLIMS/Dean Off/VAC/024**

**Date:03/07/20**

**From**

The Dean  
Sri Lakshmi Narayana Institute of Medical sciences,  
Pondicherry – 605502

**To**

The Registrar,  
Bharath Institute of Higher Education and Research,  
Chennai - 600073.

Respected Sir

**Sub:** Request for permission and approval of Syllabus for certificate course (Value Added course) for the academic year 2020-21 - Reg  
**Ref:** Requesting letter received from Departments  
\*\*\*\*\*

With reference to the above, herewith forwarding the proposed list of Value-added courses for necessary permission and approval of syllabus to conduct the same.

This is for your kind information and needful action.

Thankingyou

Yours faithfully

[DEAN]

**DEAN**  
Prof.K.BALAGURUNATHAN ,M.S  
(General surgeon)  
SRI LAKSHMI NARAYANA  
INSTITUTE OF MEDICAL SCIENCES  
OSUDU PONDICHERRY

**Encl's:**

1. Requesting letter received from department
2. Syllabus of thecourse
3. Details of faculty handlingcourse

**Sri Lakshmi Narayana Institute of Medical Sciences,  
Puducherry**

**VALUE ADDED COURSE :Audiological rehabilitation**

**COURSE CO-ORDINATOR DETAILS**

**Faculty Name:** Dr. K.R. Jothikumar

**Email ID:**entslims@gmail.com



# Bharath

INSTITUTE OF HIGHER EDUCATION AND RESEARCH  
(Declared as Deemed - to - be - University under section 3 of UGC Act 1956)

**Ref. No. BHIER/ VAC/B-02**

**Date:05.07.2020**

**From**

The Registrar,  
Bharath Institute of Higher Education and Research,  
Chennai - 600073.

**To**

The Dean  
Sri Lakshmi Narayana Institute of Medical sciences,  
Pondicherry – 605502

Sir / Madam,

**Sub:** Approval of Syllabus to conduct certificate course (Value Added course) for the academic year 2020-2021 – Reg.

**Ref:** Ref. No. SLIMS/Dean Off/VAC /024 Dated: 03.07.2020

\*\*\*\*\*

With reference to the above, it is to inform that the proposal submitted to conduct Value Added Course has been accepted and approved by BIHER, council meeting. List of the VAC are mentioned below for the academic year 2020-2021. The abstract of the VAC course completion detail should be submitted to the Registrar office.

Thanking you

Yours faithfully

  
REGISTRAR



OFFICE OF THE DEAN

## **Sri Lakshmi Narayana Institute of Medical Sciences**

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,  
PUDUCHERRY - 605 502.

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[ Affiliated to Bharath University, Chennai - TN ]

### **Circular**

07/07/2020

**Sub: Organising Value-added Course: Audiological Rehabilitation reg.**

With reference to the above mentioned subject, it is to bring to your notice that SLIMS, **Bharath Institute of Higher Education and Research**, is organising “**Audiological Rehabilitation**”. The course content and registration form is enclosed below.

The application must reach the institution along with all the necessary documents as mentioned. The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 15/07/2020. Applications received after the mentioned date shall not be entertained under any circumstances.

DEAN

**DEAN**  
Prof. K. BALAGURUNATHAN, M.S  
(General surgeon)  
SRI LAKSHMI NARAYANA  
INSTITUTE OF MEDICAL SCIENCES  
OSUDU PONDICHERRY

Encl: Copy of Course content

## VALUE ADDED COURSE

### 1. Name of the programme&Code

Audiological Rehabilitation– A value added course for the medical students.  
&ENT 01

### 2. Duration &Period

30 hrs&july 2020-dec 2020

### 3. Information Brochure and Course Content of Value AddedCourses

*Enclosed as Annexure- I*

### 4. List of students enrolled

*Enclosed as Annexure- II*

### 5. Assessment procedures:

Pre test and post test which includes 10 mcqs - *Enclosed as Annexure- III*

### 6. Certificate model

*Enclosed as Annexure- IV*

### 7. No. of times offered during the same year:

1 time july 2020- dec 2020


### 8. Year of discontinuation:2020

### 9. Summary report of each program year-wise

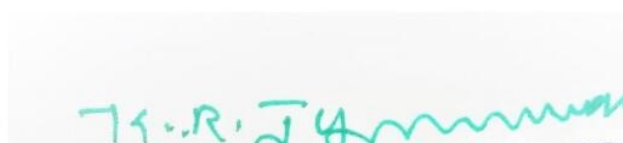
Value Added Course- July 2020- December 2020					
Sl. No	Course Code	Course Name	Resource Persons	Target Students	Strength & Year
1	ENT 01	Audiological Rehabilitation	1.Dr.Venkataramanm 2. Dr. Sreedhar.B 3.Dr. Jayagar.P	3 <sup>rd</sup> year MBBS students	15 students & 2020

### 10. Course Feed Back

*Enclosed as Annexure- V*



**RESOURCEPERSON**  
1. Dr.R.Venkataramanan  
2. Dr. P.Jayagar



**COORDINATOR**  
Dr.K.R.Jothikumar

## **COURSE PROPOSAL**

### **1.NAME OF THE PROGRAMME**

Audiological Rehabilitation– A value added course for the medical students.

### **2. AIM**

Training the students to perform Audiological Rehabilitation

### **3. OBJECTIVES**

- a) Audiological Rehabilitation for patients with hearing loss – an extensive discussion
- b) various methods of audiological rehabilitation

### **4. METHODOLOGY**

Students who are interested in participating in value added course are enrolled and the course is conducted for them during the non college hours for a period of 30 hours from July 2015 – December 2015 . This course is conducted every 6 months.

**Course Audience: 3<sup>rd</sup> year MBBS students**

**Course Coordinator: Dr.K.R. Jothikumar**

**Course Faculties with Qualification and Designation:**

**1.Dr.Venkataramanan.R**

**2.Dr. Sreedhar.B**

**3.Dr. Jayagar.P**

## Schedule followed during the course

Sl. no	COURSE TITLE	TPOICS COVERED	DURATION	Date and time
1.	Audiological Rehabilitation	Audiological rehabilitation should be an important component of most audiology practices	6hrs	4pm-6pm(20/7/20),4pm-6pm(22/7/20),4pm-6pm(24/7/20)
		Techno-centric in AR	6 hrs	4pm-6pm(17/8/20),4pm-6pm(19/8/20),4pm-6pm(21/8/20)
		Family-centered care	6 hrs	4pm-6pm(15/9/20),4pm-6pm(17/9/20),4pm-6pm(19/9/20)
		Over-the-counter (OTC) hearing aids	6 hrs	4pm-6pm(19/10/20),4pm-6pm(21/10/20),4pm-6pm(23/10/20)
		How to Begin to offer AR services	6 hrs	4pm-6pm(9/11/20),4pm-6pm(11/11/20),4pm-6pm(13/11/20)
		<b>TOTAL</b>	<b>30HRS</b>	

REFERENCE BOOKS: 1) SCOTT BROWN 6th edition

2) ANIRBAN BISWAS 1st edition



**SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES  
PUDUCHERRY**

**ANNEXURE 1**

## **Learning Outcomes**

After reading this article, professionals will be able to:

1. Discuss the implementation of Audiological rehabilitation (AR) in audiology clinical practice
2. Identify ways to include family members in the AR process
3. Identify resources for group AR intervention in practice

### **1. Do you think Audiologic rehabilitation should be an important component of most audiology practices?**

Audiologic rehabilitation (AR) most definitely is the foundation and background of audiology. However, issues exist when attempting to implement AR in practice. One of the major factors is trying to identify the meaning of the term AR. While we may acknowledge its importance and advocate its use, how AR is defined can be misunderstood and difficult to implement. There have been numerous definitions of AR over the years, some stressing fundamental aspects of therapeutic intervention such as speech reading and auditory training while others focused on the psycho-social impact of hearing loss and counseling. McCarthy and Alpiner looked back on the history of AR, its roots, and its influence in the creation of the audiology profession. One of the questions they address is the specific terminology. Historically, AR was referred to as aural rehabilitation and performed by speech-language pathologists. Ross described the aural rehabilitation services he received as an in-patient with hearing loss at the U.S. Army Walter Reed Hospital in 1952. He attended a program of therapeutic intervention for eight hours per day for eight weeks. The aural rehabilitation staff consisted of acoustic technicians, lip reading instructors, auditory training instructors, speech correctionists, psychologists and social workers, and operated through the Department of Otolaryngology. Ross believed as audiology developed as a profession, it took on an increased diagnostic role and there was a decline in AR services provided by audiologists. While AR is included in the scope of practices for both speech-language pathologists (SLP) and audiologists, the SLP tended to take the lead in AR service provision. So while it is important that AR be a part of audiology practice, we need to have a sense of what that really means.

### **2. Since both audiologists and speech-language pathologists provide AR services, how do their roles differ?**

In 1984, ASHA published a paper on the competencies necessary to provide services in aural rehabilitation. While it did acknowledge that both professions (SLPs and audiologists) were designated to provide AR services as specified in their scopes, the paper did not delineate any distinction between the two professions. It merely provided the academic background necessary to achieve competency in therapeutic delivery and provided a general definition of the term. It was not until 2001 that the roles of SLPs and audiologists in the provision of AR

services were delineated. ASHA (2001) published the AR skills and knowledge paper developed by an ad hoc committee on audiological rehabilitation. The committee was comprised of both audiologists and speech-language pathologists. The paper was designed in such a way that each profession had designated sections; Skills and Knowledge for audiologists necessary to provide AR services and the same for Speech-Language Pathologists. For example, the document states that SLPs can identify the need and refer to an audiologist for evaluation and fitting of personal and group amplification systems and sensory aids, while audiologists conduct appropriate fittings with and adjustments of these devices and technologies.

### **3. How has the definition of AR changed over the years?**

As you read the literature regarding the evolution of the definition of AR over the years, the most obvious change is conceptual. Early definitions stressed the clinical provision of service. They were task-specific and often stressing services to individuals with severe to profound hearing loss, focusing more on deafness than perhaps milder levels of hearing loss. Later definitions began to focus on the impact of hearing loss on function and included more aspects of the psycho-social elements of hearing loss and its impact on an individual's functioning ability in daily life.

The World Health Organization published a landmark paper in 2001 on International Classification of Function, Disability and Health (ICF). Most of the AR definitions published following the WHO's 2001 paper included concepts highlighted in the ICF report. Primarily, an important element was the break from considering hearing loss as a disease and rather, viewing it as a health condition that may limit activities and restrict participation in society. Relating the ICF paper to hearing loss allows us to focus our AR on what a person with an impairment can do or is capable of doing rather than their disability. Some recent definitions even use specific terminology from the ICF such as "activity limitations" and "participation restrictions" instead of disability and handicap when referring to an individual functioning with hearing loss.

### **4. Is there a definition of AR that you personally prefer?**

My AR definition, recently published in the 3<sup>rd</sup> edition of a book I authored with Jaci Spitzer, is influenced by the WHO ICF paper and stresses certain concepts pivotal to managing hearing loss. "AR is a family-centered approach to assessment and management of hearing loss that encourages the creation of a therapeutic environment conducive to a shared decision process, which is necessary to explore and reduce the impact of hearing loss on communication, activities, and participation" (Montano, 2021, p. 27). The definition stresses the practice of family-centered care and focuses its emphasis on improving communication function within the context of communication environments; this is similar in many ways to the concepts guiding the WHO's International Classification of Function.

### **5. While most audiologists acknowledge the importance of counseling, there often is not time on the schedule to allow for this. Can you address this?**

The importance of counseling in audiology is both my belief and the rule that guides my practice. While I may have an academic title, I am a working clinician seeing a full caseload of patients in our Cornell faculty practice. I take a counseling approach with every patient. Ordinarily, my patients have already had diagnostic testing performed either in my facility or

by an outside audiologist. The concept of performing a counseling-based audiologic consultation is really a matter of shifting of the emphasis of the meeting from an audiologist talking about an audiogram, to a patient talking about his or her hearing loss. In fact, unless my patient requests an explanation of his/her audiogram, I do not even discuss it. Instead, I use open-ended questions to elicit the patient's story and work with the individual and family to figure out the best possible solutions to the communication issues they have identified. A counselor, therefore, is more of a listener rather than a talker. It is important for audiologists to reject the techno-centric model of service delivery.

I have heard many audiologists report they are limited by time constraints and counseling frequently cannot be performed. My response is always the same, counseling does not require additional time in your schedule, it requires a different emphasis on how you manage the time. To me, it is far more important to learn the patient story than it is to talk about the audiogram.

#### **6. What do you mean by techno-centric?**

By techno-centric, I am saying that the services we provide focus primarily on technology. We tend to put our emphasis on the devices such as hearing aids and their accessories rather than on the hearing loss, thereby minimizing our counseling and treatment focus. Instead, it should be the patient and family that is the focus of our treatment with technology being one of the possible solutions to some communication issues. As most audiologists will agree, the hearing aid (or other amplification) alone will not solve all of life's communication problems. As reported in a qualitative study by Grenness and colleagues (2014), when patients work with an audiologist, technical competence is assumed but interpersonal relationships are valued.

#### **7. It seems you are implying that the actual audiology service delivery system interferes with audiologic counseling?**

Many times it does. Erdman, Wark and I (1994) reported on the service delivery models in audiology. Frequently, audiologists assume a medical model of service delivery, meaning, it becomes a top-down curative process as though we want to rid the person of his/her hearing loss. The authors advocated for a rehabilitative model that would be a more horizontal process where the patient becomes an equal partner in the treatment process. Erdman (2021) refers to this rehabilitation model as a bio psychosocial service delivery, which embraces counseling.

#### **8. Earlier you mentioned family-centered care. Don't we all already do this?**

I happen to agree with your assumption that indeed most audiologists believe they perform family-centered care (FCC) in their practice. However, the literature seems to suggest otherwise. Ekberg, Schuetz, Timmer, & Hickson (2020) have demonstrated that while most audiologists acknowledge the importance of FCC, there are few who have incorporated it into the daily function of their practices.

#### **9. Maybe then I need to know how you define family-centered care?**

FCC is an invitation to patients and their families to participate in the management of a person's hearing loss. As I have heard my friend Dr. Sam Trychin, a noted psychologist with severe hearing loss, say, "It is not a hearing loss, it is a communication loss." By family, I mean anyone a person with hearing loss invites to participate in his/her care; that might be a communication partner, spouse, child, sibling or friend. Together, the audiologist, person with

hearing loss and communication partner, form a therapeutic relationship that allows for the development of shared decision goals. The inclusion of family in medical treatments increases positive outcomes (Rathert, Wyrwich, & Boren, 2013) and even improves satisfaction with and uptake of amplification (Singh & Launer, 2016). My therapeutic interactions take place in a comfortable environment that welcomes family to participate in the process. There is room at the table for all and I do not sit behind a desk. Rather, we sit together around a table as equals. This seating sends a message that we are equal partners in this process. What message do you think we send when we wear a white lab coat and sit behind a huge desk? All you need to do is think back to that medical model I mentioned earlier.

**10. What components of family-centered care do you think can be easily integrated into the average audiology practice?**

Singh, Hickson, English and colleagues (2016) published a practical article that described FCC, gave it a definition and listed steps toward implementation in audiology practices. I would emphasize that, in order for a practice to adopt an FCC approach, it requires a buy-in from the entire staff including appointment clerks, secretaries and all audiologists. The first and arguably the most important step is to invite families to participate in the first place. This is accomplished easily by including the invitation with every scheduled appointment. This is a welcoming gesture and sends a positive message to the patient. Ultimately, it is the patient's decision to include family in the rehabilitation process but without an invitation they may not have considered it at all. Once scheduled, it is critical that the environment be welcoming and that family is welcomed "to the table". There can be nothing more counter-productive than to invite family to a rehabilitation session and leave them in the waiting area while the audiologist meets with the patient. The basis of FCC is that rehabilitation goals will be decided together as a team. Inclusion of family does not end with the initial consultation, but rather is encouraged for all the subsequent AR meetings.

**11. What about the current pandemic? Many practices are limiting the number of people who can attend an audiology session.**

Our practices have certainly changed a great deal in the last year. We have been struggling to re-invent ourselves and modify our practices to allow for safe treatment options with social distancing and proper infection control. Perhaps there is no patient population that has been more affected by use of face masks than people with hearing loss. The distortion of speech and lack of visual cues have made communication particularly difficult for our patient base. Here at Cornell, we actually have a policy that restricts the patients from bringing an accompanying person to medical appointments if they are capable of participating independently. This policy can certainly restrict our efforts to include family in the AR process.

If I have to find a positive aspect to the pandemic, it is the fact that audiologists have now begun to embrace telepractice. They are holding Zoom appointments and using manufacturers' distance support software to program or adjust hearing aids. I have found that the use of video visits has actually helped in the provision of FCC. I recently had an elderly patient whose son lives in Virginia and was able to participate in all her hearing related appointments. In fact, this particular patient had rejected the use of hearing aids in the past, but having her son encouraging her during the appointment resulted in her finally accepting hearing aids and wearing them on a daily basis. The use of Zoom, or even FaceTime or Skype, can allow family participants who would not ordinarily be able to participate in their loved one's treatment because of distance, work responsibilities or even illness to be a part of the rehabilitation

process.

**12. Aren't there issues regarding reimbursement for audiologists providing AR services?**

Reimbursement has always been a problem for audiologists. As a health care field, audiology is classified as a diagnostic profession. As a result, the provision of audiologic rehabilitation, being a treatment service, is for the most part, non-reimbursable. Speech-language pathologists, who are classified as both diagnostic and rehabilitative professions, can be reimbursed for AR. There has been a major push in recent years for this to change, but it requires legislative action that can take many years to achieve.

There has been a great deal of work in this area and now, as the American Academy of Audiology, The American Speech-Language Hearing Association and the Academy of Doctors of Audiology have begun working together on legislative efforts, I am beginning to feel some optimism for a change in future reimbursement for AR for audiologists.

**13. How can audiologists provide AR services without third-party reimbursement?**

It certainly would be great if third party reimbursement for AR could be available to audiologists. This however, does not mean that we cannot charge directly for the services. Still today, the most common model for hearing aid dispensing is bundling all services with the cost of the hearing aid. As a result, the patient believes they are paying for the hearing aids and thereby undervalues the services that audiologists perform. Many audiologists are already providing AR built into the hearing aid process. The ongoing counseling, training and support are all important components of the process. The problem is, patients do not realize that these services have value.

**14. This sounds like you are recommending that we unbundle audiologic services?**

Yes. I certainly acknowledge how difficult it is to shift from a bundled to an unbundled model of hearing aid dispensing. I am sure many audiologists experience it every day; a patient offers to pay for a follow-up appointment even though it was included in the cost of the hearing aid. That, of course, is determined by the professionalism of the practice. If a patient believes they are going to a store to buy a product, like perhaps the big box store model, they do not expect to pay for the service. However, when the patient believes they are receiving professional services, the value is increased. Many audiologists have begun itemizing the services they provide which then allows patients to have a better understanding of the process and cost.

**15. How do you think this will be impacted by over-the-counter (OTC) hearing aids?**

OTC hearing aids have been the talk of audiology non-stop for the past several years. I have never felt threatened by the push for new methods of hearing aid distribution; in fact, I see it as a great opportunity for audiologists and audiology. I am sure you all remember the report from the National Academy of Science, Engineering and Medicine (NASSEM) in 2016 that led to the OTC legislation in 2017. Recommendations from that report included increased insurance coverage for hearing aids and that Medicare should increase access to assessment for and delivery of (AR) including reimbursement for audiologists. This is our invitation and opportunity to distinguish ourselves from those who "sell" hearing aids to those who provide rehabilitation and management of hearing loss. My advice is to embrace the new avenues for

amplification and provide the services that make us audiologists.

**16. If I want to begin to offer some AR services, where should I start?**

I believe that most audiologists are already providing some form of AR. Certainly, counseling is a huge part of everything we do. I always say that counseling begins the moment we greet our patient in the waiting room and the relationship starts when the first appointment is booked. I still think that many people consider traditional therapeutic interventions like speechreading and auditory training as AR. While some may offer these services, it certainly is the minority of providers. Frequently patients are referred to online training programs like cLEAR (Tye-Murray, Spehar, Sommers, & Barcroft, 2016) and LACE (Sweetow & Sabes, 2006). Research in the areas of auditory training and speechreading is not very strong and there is a lack of evidence and outcomes. However, group AR intervention has been shown to improve outcomes and has evidenced-based research to support its implementation (Hawkins, 2005; Chisolm & Arnold, 2012).

**17. Most of us do not have any experience offering group therapy, where can we obtain resources?**

There are many resources available to audiologists that can help with the creation and implementation of group AR. The Active Communication Education program (ACE; Hickson, Worrall, & Scarinci, 2007) is an evidence-based group treatment program that is available free through the University of Queensland, Australia. Audiologists can have access to strategies and actual lesson plans for administering the program. Another excellent resource available, also free, is on the Ida Institute website ([idainstitute.com](http://idainstitute.com)). They established a program referred to by the acronym GROUP that stands for "group rehabilitation online utility pack". GROUP allows users access to videos, sample lessons and suggestions for short or lengthy group programs. While most audiologists are apprehensive about running groups, one only has to try it to experience how rewarding it can be for patients, families, and providers. When we provide group AR at Cornell, our feedback is always positive and frequently results in word of mouth referrals.

**18. How do you implement groups in your facility?**

At Cornell, we use the ACE evidenced-base group AR program as the basis for our service. We advertise in our building lobby and office areas and keep a list of patients who have expressed interest in participation. We refer to it as a communication group and not a hearing aid group. Participants do not have to be hearing aid users nor even existing patients at Cornell. We do, in fact, charge for participating in the AR group, and it is not included in the price of the hearing aids. While the charge is minimal, it adds value to the service. We offer the program twice a year one evening a week for five weeks. Just recently, during the COVID, we held a well-received Zoom AR group. Our patients are always encouraged to bring a communication partner to all meetings. Prior to COVID restrictions, we held the meeting in our conference room and participants sat in a circle. Every week we covered a different topic about living with hearing loss. I refer you to the Ida institute GROUP site for specific suggestions on some activities you can implement. I have always taken a "field of dreams" attitude on offering group intervention, "If you build it, people will come."

**19. Do you also include other outside services?**

In my facility, I am fortunate to have both audiologists and speech-language pathologists (SLPs) on my staff. We have the ability to refer to our SLPs when our patients need traditional AR services like speechreading and auditory training. In addition to offering group intervention for our patients with hearing loss, we are fortunate to have a local chapter of the Hearing Loss Association of America (HLAA) nearby. Many of our patients participate in the chapter and are grateful for the peer support they receive at the meetings and on the HLAA website.

**20. Are you optimistic about the future of AR and Audiology?**

Most definitely! We currently only reach a small percentage of people with hearing loss who can benefit from our services. As technology increases and more people begin to avail themselves of amplification options, the opportunity to provide audiology care will only increase. What I am most hopeful for is that the hearing aid will no longer be the focus of our practices but rather just another tool in the arsenal we already have to help patients manage their hearing loss. I am hopeful that AR services will soon become a reimbursable treatment option for audiologists and we will begin to shift our focus back to the communication needs of our patients through the provision of counseling, therapies and group interventions. I believe the future is indeed bright and encourage all audiologists to set forth on the AR road.

**Annexure 2**  
**Bharath Institute of Higher Education and Research**  
**SLIMS**

1	NIVETHA.R	U12MB264
2	PARIDASAN.P	U12MB266
3	PAVITHRAN.P	U12MB267
4	PRIYADHARSHINI.K	U12MB272
5	PRIYANKA.M	U12MB276
6	RAJESHWARI.I	U12MB281
7	REKA.D	U12MB286
8	SANKAR.C	U12MB291
9	SASIDHARAN.A	U12MB294
10	SIBIE CASTRO.J	U12MB299
11	SIVA RANJANI.T	U12MB303
12	SIVA PRAKASH.M	U12MB305
13	SOWMIYA DEVI.V	U12MB309
14	STEPHEN BUSH.P	U12MB311
15	VIGNEH.V	U12MB336



ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL  
SCIENCES

PUDUCHERRY

TOPIC: Audiological Rehabilitation (ENT 01 )

STUDENT NAME:

UNIVERSITY NO:

1. The most common cause of conductive hearing loss in young children is:  
a. Rubella.                      b. Impacted cerumen.  
c. Meningitis.                  d. Otitis media.
  
2. Which cranial nerve would be affected by an acoustic neuroma?  
a. V                                b. VII  
c. VIII                            d. IX
  
3. For typically developing children, the most common substitution for a prevocalic liquid is:  
a. another liquid.              b. a glide.  
c. a front vowel.                d. a rounded vowel.
  
4. Velopharyngeal inadequacy may compromise the ability to build up intra-oral air pressure during speech. Which consonant sound will be most noticeably affected?  
a. /j/                              b. /r/  
c. /m/                              d. /s/
  
5. Prior to selection of a augmentative communication system, fine motor control is carefully assessed to determine:  
a. the minimum physical size of a target vocabulary item.  
b. the type of vocabulary used (i.e. pictures versus letters).  
c. the method of vocabulary manipulation (sentence versus one-word responses).  
d. method of output (voice or printed or visual display).
  
6. pH monitoring is used to assess:  
a. esophageal motility.              b. achelasia.  
c. gastroesophageal reflux.        d. esophageal strictures.
  
7. For which of the following dysarthrias would intensive drill in over articulation be contraindicated?  
a. Spastic dysarthria resulting from cerebrovascular accident.  
b. Flaccid dysarthria resulting from myasthenia gravis.  
c. Flaccid dysarthria associated with Bell's palsy.  
d. Ataxic dysarthria resulting from cerebellar damage.

8. A young infant will typically stick out the tongue when the tip is touched. This is known as the :

- a. rooting reflex.
- b. suckling reflex.
- c. sucking reflex.
- d. tongue protrusion reflex.

9. When the transmission of sound energy is blocked in the pharynx, an individual's resonance will sound:

- a. muffled.
- b. hypernasal.
- c. hyponasal.
- d. mixed (both hypernasal and hyponasal).

10. Which muscle plays the greatest role in velopharyngeal closure?

- a. Palatoglossus.
- b. Levator veli palatini .
- c. Tensor veli palatini .
- d. Superior pharyngeal constrictor.

PRE TEST

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES  
PUDUCHERRY

TOPIC: Audiological Rehabilitation (ENT 01)

STUDENT NAME: VIGNESH V

UNIVERSITY NO: V12MB336

6

1. The most common cause of conductive hearing loss in young children is:

- a. Rubella.                      b. Impacted cerumen.  
c. Meningitis.                  d. Otitis media.

2. Which cranial nerve would be affected by an acoustic neuroma?

- a. V                                  b. VII  
c. VIII                              d. IX

X

3. For typically developing children, the most common substitution for a prevocalic liquid is:

- a. another liquid.                  b. a glide.  
c. a front vowel.                      d. a rounded vowel.

4. Velopharyngeal inadequacy may compromise the ability to build up intra-oral air pressure during speech. Which consonant sound will be most noticeably affected?

- a. /t/                                  b. /r/  
c. /m/                                  d. /s/

X

5. Prior to selection of an augmentative communication system, fine motor control is carefully assessed to determine:

- a. the minimum physical size of a target vocabulary item.  
b. the type of vocabulary used (i.e. pictures versus letters).

- c. the method of vocabulary manipulation (sentence versus one-word responses).  
d. method of output (voice or printed or visual display).

6. pH monitoring is used to assess:

- a. esophageal motility.      b. achelasia.  
c. gastroesophageal reflux.      d. esophageal strictures.

7. For which of the following dysarthrias would intensive drill in over articulation be contraindicated?

- a. Spastic dysarthria resulting from cerebrovascular accident.  
b. Flaccid dysarthria resulting from myasthenia gravis.  
 c. Flaccid dysarthria associated with Bell's palsy.  
d. ~~Ataxic~~ dysarthria resulting from cerebellar damage.

8. A young infant will typically stick out the tongue when the tip is touched. This is known as the :

- a. rooting reflex.      b. suckling reflex.  
c. sucking reflex.      d. ~~tongue~~ protrusion reflex.

9. When the transmission of sound energy is blocked in the pharynx, an individual's resonance will sound:

- a. muffled.      b. ~~hypernasal~~.  
c. hyponasal.      d. mixed (both hypernasal and hyponasal).

10. Which muscle plays the greatest role in velopharyngeal closure?

- a. Palatoglossus.      b. Levatorvelipalatini .  
 c. ~~Tensor~~ velipalatini .      d. Superior pharyngeal constrictor.

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES  
PUDUCHERRY

TOPIC: Audiological Rehabilitation (ENT 01)

STUDENT NAME: Reka . D

UNIVERSITY NO: V 12 MB286

3

1. The most common cause of conductive hearing loss in young children is:

- a. Rubella.                      b. Impacted cerumen.  
c. Meningitis.                  d. Otitis media.

2. Which cranial nerve would be affected by an acoustic neuroma?

- X a. V                              b. VII  
c. VIII                          d. IX

3. For typically developing children, the most common substitution for a prevocalic liquid is:

- a. another liquid.              b. a glide.  
X c. a front vowel.                d. a rounded vowel.

4. Velopharyngeal inadequacy may compromise the ability to build up intra-oral air pressure during speech. Which consonant sound will be most noticeably affected?

- a. /j/                              b. /r/  
c. /m/                              d. /s/

5. Prior to selection of an augmentative communication system, fine motor control is carefully assessed to determine:

- X a. the minimum physical size of a target vocabulary item.  
b. the type of vocabulary used (i.e. pictures versus letters).

- c. the method of vocabulary manipulation (sentence versus one-word responses).  
d. method of output (voice or printed or visual display).

6. pH monitoring is used to assess:

- X a. esophageal motility.      b. achelasia.  
c. gastroesophageal reflux.      d. esophageal strictures.

7. For which of the following dysarthrias would intensive drill in over articulation be contraindicated?

- a. Spastic dysarthria resulting from cerebrovascular accident.  
b. Flaccid dysarthria resulting from myasthenia gravis.  
c. Flaccid dysarthria associated with Bell's palsy.  
d. Ataxic dysarthria resulting from cerebellar damage.

8. A young infant will typically stick out the tongue when the tip is touched. This is known as the :

- X a. rooting reflex.      b. suckling reflex.  
c. sucking reflex.      d. tongue protrusion reflex.

9. When the transmission of sound energy is blocked in the pharynx, an individual's resonance will sound:

- a. muffled.      b. hypernasal.  
c. hyponasal.      d. mixed (both hypernasal and hyponasal).

10. Which muscle plays the greatest role in velopharyngeal closure?

- a. Palatoglossus.      b. Levatorvelipalatini .  
c. Tensor velipalatini .      d. Superior pharyngeal constrictor.

## POST TEST

- c. the method of vocabulary manipulation (sentence versus one-word responses).
- d. method of output (voice or printed or visual display).

6. pH monitoring is used to assess:

- a. esophageal motility.
- b. achalasia.
- c. gastroesophageal reflux.
- d. esophageal strictures.

7. For which of the following dysarthrias would intensive drill in over articulation be contraindicated?

- a. Spastic dysarthria resulting from cerebrovascular accident.
- b. Flaccid dysarthria resulting from myasthenia gravis.
- c. Flaccid dysarthria associated with Bell's palsy.
- d. Ataxic dysarthria resulting from cerebellar damage.

8. A young infant will typically stick out the tongue when the tip is touched. This is known as the :

- a. rooting reflex.
- b. suckling reflex.
- c. sucking reflex.
- d. tongue protrusion reflex.

9. When the transmission of sound energy is blocked in the pharynx, an individual's resonance will sound:

- a. muffled.
- b. hypernasal.
- c. hyponasal.
- d. mixed (both hypernasal and hyponasal).

10. Which muscle plays the greatest role in velopharyngeal closure?

- a. Palatoglossus.
- b. Levator velopalatini.
- c. Tensor velopalatini.
- d. Superior pharyngeal constrictor.

6

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

PUDUCHERRY

TOPIC: Audiological Rehabilitation (ENT 01)

STUDENT NAME: *Rekha D*

UNIVERSITY NO: *U12MB286*

1. The most common cause of conductive hearing loss in young children is:

- a. Rubella.      b. Impacted cerumen.  
 c. Meningitis.      d. Otitis media.

2. Which cranial nerve would be affected by an acoustic neuroma?

- a. V      b. VII  
 c. VIII      d. IX

3. For typically developing children, the most common substitution for a prevocalic liquid is:

- a. another liquid.      b. a glide.  
 c. a front vowel.      d. a rounded vowel.

4. Velopharyngeal inadequacy may compromise the ability to build up intra-oral air pressure during speech. Which consonant sound will be most noticeably affected?

- a. /l/      b. /r/  
 c. /m/      d. /s/

5. Prior to selection of an augmentative communication system, fine motor control is carefully assessed to determine:

- a. the minimum physical size of a target vocabulary item.  
 b. the type of vocabulary used (i.e. pictures versus letters).



- c. the method of vocabulary manipulation (sentence versus one-word responses).  
d. method of output (voice or printed or visual display).

6. pH monitoring is used to assess:

- a. esophageal motility.      b. achalasia.  
~~c. gastroesophageal reflux.~~      d. esophageal strictures.

7. For which of the following dysarthrias would intensive drill in over articulation be contraindicated?

- a. Spastic dysarthria resulting from cerebrovascular accident.  
~~b. Flaccid dysarthria resulting from myasthenia gravis.~~  
c. Flaccid dysarthria associated with Bell's palsy.  
d. Ataxic dysarthria resulting from cerebellar damage.

8. A young infant will typically stick out the tongue when the tip is touched. This is known as the:

- ~~a. rooting reflex.~~      b. suckling reflex.  
c. sucking reflex.      d. tongue protrusion reflex.

9. When the transmission of sound energy is blocked in the pharynx, an individual's resonance will sound:

- ~~a. muffled.~~      ~~b. hypernasal.~~  
c. hyponasal.      d. mixed (both hypernasal and hyponasal).

10. Which muscle plays the greatest role in velopharyngeal closure?

- a. Palatoglossus.      ~~b. Levator velipalatini.~~  
c. Tensor velipalatini.      d. Superior pharyngeal constrictor.

7

ANNEXURE 3

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES  
PUDUCHERRY

TOPIC: Audiological Rehabilitation (ENT 01)

STUDENT NAME: Vignesh . V

UNIVERSITY NO: U12MB336

1. The most common cause of conductive hearing loss in young children is:  
a. Rubella.                      b. Impacted cerumen.  
c. Meningitis.                      ~~d. Otitis media.~~
2. Which cranial nerve would be affected by an acoustic neuroma?  
a. V                                      b. VII  
~~c. VIII~~                                      d. IX
3. For typically developing children, the most common substitution for a prevocalic liquid is:  
a. another liquid.                      ~~b. a glide.~~  
c. a front vowel.                      d. a rounded vowel.
4. Velopharyngeal inadequacy may compromise the ability to build up intra-oral air pressure during speech. Which consonant sound will be most noticeably affected?  
a. /j/                                      b. /r/  
~~c. /m/~~                                      d. /s/
5. Prior to selection of a augmentative communication system, fine motor control is carefully assessed to determine:  
~~a. the minimum physical size of a target vocabulary item.~~  
b. the type of vocabulary used (i.e. pictures versus letters).

ANNEXURE 4



**Annexure 5**  
**Course/Training Feedback Form**  
**Student Feedback Form**

Course Name: Audiological Rehabilitation

Subject Code: **ENT01**

Name of Student: \_\_\_\_\_ Roll No.: \_\_\_\_\_

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					
2	Course contents met with your expectations					
3	Lecturer sequence was well planned					
4	Lectures were clear and easy to understand					
5	Teaching aids were effective					
6	Instructors encourage interaction and were helpful					
7	The level of the course					
8	Overall rating of the course	1	2	3	4	5

*\* Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

Annexure 5

Course/Training Feedback Form

Student Feedback Form

Course Name: Audiological Rehabilitation

Subject Code: ENT01

Name of Student: VIGNESH Y Roll No.: UI2MB336

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear		✓			
2	Course contents met with your expectations			✓		
3	Lecturer sequence was well planned		✓			
4	Lectures were clear and easy to understand				✓	
5	Teaching aids were effective				✓	
6	Instructors encourage interaction and were helpful			✓		
7	The level of the course		✓			
8	Overall rating of the course	1	2	3	4	5

\* Rating: 5 - Outstanding; 4 - Excellent; 3 - Good; 2 - Satisfactory; 1 - Not-Satisfactory

Suggestions if any:

good

Annexure 5

**Course/Training Feedback Form**

**Student Feedback Form**

Course Name: Audiological Rehabilitation

Subject Code: ENT01

Name of Student: SIBIE CASTRO Roll No.: U12MB249

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear			/		
2	Course contents met with your expectations			/		
3	Lecturer sequence was well planned			/		
4	Lectures were clear and easy to understand		/		/	
5	Teaching aids were effective		/			
6	Instructors encourage interaction and were helpful				/	
7	The level of the course				/	
8	Overall rating of the course	1	2	3	4	5

\* Rating: 5 - Outstanding; 4 - Excellent; 3 - Good; 2 - Satisfactory; 1 - Not-Satisfactory

Suggestions if any:

Excellent

ANNEXURE 6

Date : 15/12/2020

From  
Dr.K.R. Jothikumar,  
Dept of Otorhinolaryngology,  
SLIMS  
Bharath Institute of Higher Education and Research,  
Puducherry.

Through Proper Channel

To  
The Dean,  
SLIMS,  
Bharath Institute of Higher Education and Research,  
Puducherry.

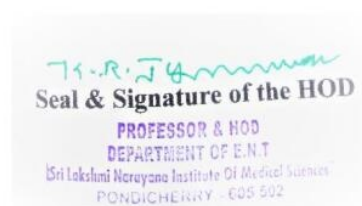
**Sub: Completion of value-added course: Audiological Rehabilitationreg.**

Dear Sir,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **Audiological Rehabilitation** on July 2020 to Dec 2020. We solicit your kind action to send certificates for the participants, that is attached with this letter. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards

Dr.K.R.Jothikumar  
<HOD Sign and Seal>



ANNEXURE 7

