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COMPREHENSIVE
AUDIOLOGY
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REFERRAL FOR AUDIOLOGY SERVICES

Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____

Reason for Referral:

- ☐ Audiologic Evaluation (with Diagnostic Report)
- ☐ Hearing Aid Evaluation/Hearing Aid Check
- ☐ Tympanogram
- ☐ Otoacoustic Emissions (OAE)
- ☐ Newborn Hearing Screening
- ☐ Custom Ear Plugs: ____ Swim ____ Noise ____ Musician
- ☐ Medical Clearance for Hearing Aids
  Please list any contraindications below _____
- ☐ Other: _____

Referring Physician: _____ NPI: _____

Physician Phone: _____ Fax: _____

Physician Signature/Stamp: _____

☐ Check if more referral pads are needed