From:	To: Referrals
Phone:	Phone: 704-412-7975
Fax:	Fax: 888-965-9948
Contact email:	

AUDIOLOGY TESTING REFERRAL FORM

To Physicians' Offices: Thank you for this referral! Please complete this form and fax to (888) 965-9948.

Patient name: ____ DOB: ______________________________

Address: ____ Phone: ____________________________

____ ____________________________

MD office – please complete this section

MD order:
_____ Audiologic Evaluation
_____ Auditory Processing Disorder Eval
_____ Hearing Aid Consultation
_____ Ototoxic Monitoring
_____ Diabetic Annual Eval
_____ Other (specify) _______________
____
____

Diagnosis:
_____ Hearing Loss
_____ Sudden Hearing Loss
_____ Tinnitus
_____ Speech/Lang Delay
_____ Diabetes
_____ Sound Sensitivity
_____ Symptoms Assoc. w/ Oto-toxic Drugs
____ Meniere's Disease
____ Cardiovascular Disease
____ Noise-Induced Hearing Loss
____ Other: _________________

Please sign and fax to: 888-965-9948

MD Signature: _______________________________ Date: ____________________________________

Appointment Scheduled: ____________________________________