Audiology Referral

Patient Name: _____ DOB: _____

Patient Phone: _____

*Please send copy of patient's insurance cards.

Diagnosis Code:	
Specific concern regarding hearing or ears:	_____ Hearing Loss _____ Tinnitus _____ Vertigo/Balance Problem _____ Ototoxicity _____ Noise Exposure _____ Other: _____
Requested Tests:	_____ Evaluate for hearing loss per standard protocol (includes comprehensive hearing eval and, when when needed, tympanometry) _____ Comprehensive Hearing Evaluation _____ Tympanometry (middle ear measurement) _____ Special Test: _____

Physician Signature: _____ Date: _____

Print Physician Name: _____

NPI: _____