Hearing Care Referral Form

Patient Information

Date: _____

Patient Name: _____

Age: _____ Birthdate: _____

Telephone: _____

Insurance: _____

Relevant Clinical Information:

_____

_____

Is there medical contra-indication to hearing aid use? Yes / No

Please assess/provide:

- ☐ Diagnostic Hearing Evaluation and Consultation
- ☐ Tinnitus Management
- ☐ Custom Ear Plugs *(circle as appropriate)*: Noise / Swim / Musician / Security
- ☐ Hearing aid consultation and fitting, where indicated
- ☐ Neurodiagnostic Vestibular Testing
- ☐ Other: _____

_____

Send results by *(circle as appropriate)*:
Mail / Fax / Email _____

Referred to:

Texas Professional Hearing Center
234 W Cedar Bayou Lynchburg Rd,
Baytown, TX 77521 •Tel: 281-918-4397

Referred by:

Physician's Signature:

_____

Print Phys. Name: _____

NPI: _____

Office Address: _____

_____