Print Form

The Hearing Clinic BANKSTOWN

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Prov. No.: 049591CK

REFERRAL FORM

Patient's Name _____ Date _____

Address _____ D.O.B. _____

_____ Postcode _____

Telephone: Home _____ Business _____

Appointment Date _____ **Time** _____

SERVICES REQUIRED

- ☐ AUDIOGRAM (incl. Tympanometry)
- ☐ A.B.R. (Auditory Brainstem Response test)
- ☐ CERA (Cortical Evoked Response Audiometry)
- ☐ V.E.M.P. (Vestibular Evoked Potentials)
- ☐ PRE-EMPLOYMENT TESTING
- ☐ EAR PLUGS (Swimmers/Musicians/Noise)
- ☐ HEARING AID ASSESSMENT
- ☐ COCHLEAR IMPLANT ASSESSMENT
- ☐ BAHA (Bone Anchored Hearing Aid) Assessment)

PAEDIATRIC TESTING

- ☐ PLAY AUDIOMETRY/VROA (Incl. Tympanometry) < 5yr olds
- ☐ O.A.E. TESTS (Oto-Acoustic Emission Tests)
- ☐ CAPD (Central Auditory Processing Assessment)

Reason for Referral _____

_____

Doctor's Signature _____

Doctor's Name _____ Provider No. _____

Address _____

Accredited by the OHS to provide hearing aids for pensioners & DVA clients