PLEASE COMPLETE THIS FORM AND FAX IT WITH CLINICAL NOTES AND A COPY OF PATIENT INSURANCE CARD.

PATIENT INFORMATION

Name _____

Address _____

City/St/Zip _____

Phone _____

Alt Phone _____

Date of Birth _____ Age _____

Primary Insurance _____

ID # _____

Secondary Insurance _____

ID # _____

REFERRING PHYSICIAN INFORMATION

Physician _____

Practice Name _____

Address _____

City/St/Zip _____

Phone _____

Fax _____

NPI # _____

Contact / Referral Person _____

Thank you for your referral !

HEARING TESTING & TREATMENT

____ Audiologic Evaluation (Adult)
____ Audiologic Evaluation (Child)
____ High Frequency Audio Evaluation (Ototoxicity Monitoring)
____ Audiologic Tinnitus Evaluation
____ Auditory Brainstem Response (ABR)
____ Newborn Hearing Screening (BAER)
____ Otoacoustic Emissions (OAE)
____ Central Auditory Processing (APD) Testing

____ Cerumen (Earwax) Removal
____ Hearing Aid or ALD Consultation
____ Hearing Protection, Swim Molds, Musician Plugs, Other

BALANCE / DIZZINESS TESTING & TREATMENT

____ Evaluate and/or Treat (Comprehensive Assessment)
____ ENG / VNG
____ Positional testing and calorics only
____ Electrocochleography (ECochG)
____ Vestibular Evoked Myogenic Potential (VEMP)
____ Posturography (SOP, EQT / CDP)
____ Rotary Chair

____ Canalith Repositioning Treatment (Epley) for BPPV
____ Vestibular Therapy (limited, please call)

DX: _____

Notes / Comments: _____

_____

Physician Signature: _____ DATE: _____