

Hearing Care Referral

Patient's Name _____

DOB ____ / ____ / _____

Relevant Clinical information

Is this under a Medicare Plus Plan?

Yes (EPC referral form to be attached) No

Please assess/provide:

- Adult Hearing Assessment
- Paediatric Hearing Assessment (Specific locations)
- Tympanometry and Stapedial Reflexes
- Industrial Audiology (Percentage Hearing Loss)
- Pre- / Employment Test (Diving/Aviation/Police/Travel)
- Tinnitus Management
- Custom Ear Plugs (Noise / Swim / Musician / Security)
- Mines Workers Health Surveillance
(Air conduction and lung function) / (WA specific locations)
- Other - please specify _____

Hearing Aid Prescription:

- Hearing aid consultation
- Please fit patient with hearing aids on your usual trial basis
- Any special considerations? _____

Your local centre is

Bill to third party

Referring Doctor's Details

Dr _____

Provider No# _____

Address _____

Ph _____

Fax _____

Email _____

Signature _____

Date ____ / ____ / _____

Send Results by Mail / Fax / Email



To speak to a Clinician at your local Connect Hearing Centre

Phone **1300 656 858**

www.connecthearing.com.au