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Audiology Services Referral Form

If you have Medicare or your primary insurance plan requires a referral, please contact your primary care physician before your appointment for referral. Print out this form. Complete the Patient Information section and have your primary care physician check the reason for referring and sign this form.

Date:_______________

Patient Name:____ Date of Birth:_________________________

Patient Phone Number:________________________________

Reason for Referral:

- ☐ Diagnostic hearing evaluation and hearing aid consultation if needed.
- ☐ Other reason, please describe ___________________________________

Referring Physician:_______________________________________

Referring Physician Signature:_______________________________________