

# Referral for Hearing Services



ABN: 91 087 971 051

## Patient details:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Pension number: \_\_\_\_\_

## Please conduct the following:

- Hearing Assessment (patients over 5 years of age)
- Air Conduction
- Air and Bone Conduction
- Speech Discrimination
- Tympanometry
- Other \_\_\_\_\_
- Tinnitus Management
- Custom-made Plugs
- Hearing Loss Solutions

Are there contraindications to the fitting of a hearing device?

- Yes (May still be eligible for other hearing services)  No

## Clinic notes:

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## Doctor details:

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic name: \_\_\_\_\_

Provider number: \_\_\_\_\_

Stamp details here