

Referral for Hearing Services



Patient details:

First name: _____ Last name: _____

Phone number: _____ Date of birth: _____

Pension number: _____

Please conduct the following:

- Hearing Assessment (patients over **18** 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:

Doctor details:

Date: _____

Name: _____

Clinic name: _____

Provider number: _____

Stamp details here