

Patient Information:

Date: _____

PATIENT LABEL HERE

Referral Information

<input type="checkbox"/> Routine Audiogram and Tymp
<input type="checkbox"/> Urgent or Semi urgent. Please provide a preferred timeline _____
<input type="checkbox"/> Sudden Hearing Loss. When did the loss occur? _____ Prednisone? _____
<input type="checkbox"/> PreOP or PostOP. What surgery & when? _____
<p>Please check off any of the following that apply:</p> <input type="checkbox"/> Tympanic Membrane Perforation <input type="checkbox"/> Asymmetric loss (Left OR Right) <input type="checkbox"/> Dizziness <input type="checkbox"/> Tinnitus <input type="checkbox"/> Otagia <input type="checkbox"/> Pressure/Fullness <input type="checkbox"/> Discharge/Otorrhea/Ear Infection <input type="checkbox"/> Other information we should be aware of _____ _____

***If possible, please include any previous audiograms.

Referral Source

Name:	Location:	
PracID:	Phone:	Fax: