DILWORTH HEARING

Patient Referral

Attach patient label here if available

Name: _____

Address: _____

Phone: _____ Date of Birth: _____

Referred for:

- ☐ Free hearing screening
- ☐ Adult diagnostic hearing assessment
- ☐ Hearing aid assessment and fitting
- ☐ Tinnitus/Hyperacusis assessment
- ☐ Child hearing testing (age: _____)
- ☐ Auditory Processing testing (7+yrs)
- ☐ Custom ear plugs
- ☐ Wax removal
- ☐ Cochlear implant assessment
- ☐ High-frequency audiometry
- ☐ Balance testing (Christchurch only)
- ☐ Other

Comments: *e.g. relevant patient history, reason for referral*

Doctor's Stamp:

You can also refer electronically via Medtech or ERMS.