Neurosensory

YOUR NEXT APPOINTMENT IS ON:

Date ___ /___ /___ Time ___ : ___ am pm

Clinic

Patient Details

First Name _____ Surname _____

Address _____

Phone (H) _____ Mobile _____ DOB _____ /_____ /_____

Clinical History

_____

_____

_____

General Testing

- ☐ Hearing Assessment (from 9 months of age; includes audiometry, middle ear function, speech audiometry and if clinically indicated, otoacoustic emissions).
  - ☐ Medicolegal
  - ☐ Pre-Employment Hearing Test
- ☐ Hearing Aid Assessment
- ☐ Cochlear Implant Assessment
- ☐ Bone Conduction Implant Assessment
- ☐ Tinnitus Consultation
  - ☐ Tinnitus Management Program
- ☐ Auditory Processing Assessment (>6 years)
- ☐ Otoacoustic Emissions

Further Testing

- ☐ Balance Assessment (vHIT, VEMP, VNG, Calorics)
- ☐ Electrocochleography, *Extratympanic* (ECOG)
  - ☐ Fistula Test
- ☐ Auditory Brainstem Response (ABR)

Ear and Hearing Protection

- ☐ Custom Swim Plugs
- ☐ Custom Musician & Noise Plugs
- ☐ Custom MP3 Earbuds

Referral to:

Name _____

Provider # _____

Signature _____

Copy Report To:

Name _____

Provider # _____

Referral Date _____ /_____ /_____