

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, Caloric)
- Electrocochleography, *Extratympanic* (ECOG)
 - Fistula Test
- Auditory Brainstem Response (ABR)

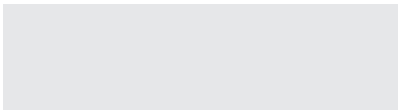
Ear and Hearing Protection

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

Referral to:

Name _____

Provider # _____



Signature _____

Copy Report To:

Name _____

Provider # _____

Referral Date ___/___/___