

**YOUR NEXT APPOINTMENT IS ON:**

Date \_\_\_/\_\_\_/\_\_\_ Time \_\_\_ : \_\_\_ am pm  
Clinic

**Patient Details**

First Name \_\_\_\_\_ Surname \_\_\_\_\_  
Address \_\_\_\_\_  
Phone (H) \_\_\_\_\_ Mobile \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

**Clinical History**

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**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)

**Further Testing**

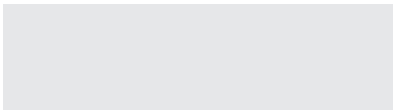
- Balance Assessment (vHIT, VEMP, VNG, Calorics)
- Electrocochleography, *Extratympanic* (ECOG)
  - Fistula Test
- Auditory Brainstem Response (ABR)

**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 \_\_\_/\_\_\_/\_\_\_