Referral for Audiology

HealthLink EDI: chelhear

Patient Details:

Name: _____

Date of birth: _____

Phone: _____

Services Requested:

- ☐ Audiological assessment - air and bone conduction, speech discrimination, impedance, oto-acoustic emissions
- ☐ Hearing aid consultation
- ☐ Custom ear plugs (swim, noise, music)
- ☐ Other (please provide details in notes section)

Additional Information:

- ☐ Patient at risk of hearing loss due to ototoxic medication or medical intervention
- ☐ Patient at risk of noise induced hearing loss

Notes:

Referring Doctor Details:

Name: _____

Provider Number: _____

Clinic: _____

Signature: _____

Date: _____

Chelsea Hearing Pty Ltd
Suite 3, 8 The Strand, Chelsea 3196
HealthLink EDI: chelhear Phone: 03 8740 2135 Fax: 03 8609 1858