HearSafe Solutions

Referral for Audiology

Patients Name: _____

Address: _____

Tel: _____ D.O.B.: ____/____/____

☐ OHS Service ☐ Workcover ☐ Veteran Services ☐ Other _____

Referred for

☐ Hearing Assessment (adult)

☐ Pediatric Hearing Assessment (5 years and above)

☐ Tympanometry (all ages)

☐ Pre-Employment Test

☐ Wax Removal

☐ Hearing Aids

☐ Workcover Hearing Assessment

☐ Custom Ear Plugs

☐ Tinnitus Evaluation & Counselling

☐ Other _____

Referring Doctor _____

Name: _____

Address: _____

Tel: _____ Date: ____/____/____

Signature: _____ Provider Number: _____

Referrer Details/Stamp Date____/__/____

Provider No: