Audiology
Referral

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Send referral to: EMAIL: admin@bundaberghearing.com.au or FAX: 07 3130 4453

Patient Name: _____DOB: _____

Patient Address: _____

Patient Phone: _____

Referring Doctor: _____ Provider #:_____

COMMENTS:

☐ **There are no contraindications for Hearing Aid fitting (both / L / R)**

Doctor's Signature: _____ Date: _____

☐ **Adult Hearing Assessment** (Pure Tone Audiometry, Speech Audiometry, Immittance/Middle Ear testing. Sudden hearing loss should be evaluated immediately)

☐ **Adult Hearing Aid Fitting, Rehabilitation or Optimisation** (All adults >25yrs)

☐ **Adult Cochlear Implant or Hearing/Bone Implant candidacy evaluations & mapping**

☐ **Tinnitus and Sound Intolerance Assessments & Management** (e.g. Hyperacusis, Misophonia)

☐ **Ear wax Microsuctioning** (Adults and Children)

☐ **Paediatric Hearing Assessment Aged 4+** (Referral should specify if the assessment is related to a Complex Neurodevelopmental Disorder e.g. ASD, ADHD)

☐ **Auditory Processing Disorder Assessment** (Age 7+ for diagnosis/Age 4-6 for early screening)

☐ **Workcover and Occupational or Employment Assessments**

☐ **Custom Earplugs** (swimming, musician, noise, shooting, motorsport, industry, sleep)