

Audiology Referral Form

HARLEY
· STREET ·
HEARING

Patient Name

Date of Birth

Phone

Email

Insurance Provider

Provider Number

Authorisation Code

Address

Referred by

Hearing Aids and Management (please tick where appropriate)

- | | |
|--|--|
| <input type="checkbox"/> Hearing Aid Assessment / Trial | <input type="checkbox"/> Vestibular Rehabilitation |
| <input type="checkbox"/> Lyric Assessment / Trial | <input type="checkbox"/> Ear Wax Removal / Microsuction |
| <input type="checkbox"/> Tinnitus / Hyperacusis Management (Hearing Therapy) | <input type="checkbox"/> Custom Hearing Protection (Musicians, Shooting, Sleeping, Swimming) |
| <input type="checkbox"/> Auditory Training Therapy / Management | <input type="checkbox"/> Custom Presenter Earpieces |

Investigations (please tick where appropriate)

- Pure Tone Audiometry
- Tympanometry
- Acoustic Reflex Thresholds
- Speech Audiometry
- Uncomfortable Loudness Levels
- Tinnitus / Hyperacusis Assessment
- Auditory Processing Disorder Assessment
- Eustachian Tube Dysfunction Test
- Vestibular Assessment (vHIT, C-VEMP, O-VEMP, VNG, Positioning & Calorics)

Please identify if your patient has contraindications to any of the above mentioned tests in relevant history

Relevant History

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Thank You For Your Referral

020 7486 1053
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musicians'
hearing
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protecting your
musical future