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REFERRAL FORM
FAX TO: 802-366-8030

Today's Date: ________________________

Patient Name: ____

Parent / Guardian (please forward copies of legal document) Name: ____________________________________

Street Address: ____________________________ ____

City: ________________________________ State: ______________ Zip Code: _________________________

DOB: ________________ SS#: ____________________ Home / Cell Phone: (____)__________________

Insurance Carrier: ________________________Policy #:________________________ Group #: __________

Subscriber Name: _________________________________ Subscriber DOB: __________________________

REASON FOR VISIT:____

Referring Physician: _______________________________ Office Fax: _______________________________

<u>Please fax all information</u> relevant to your patient's visit with us. This form allows us to obtain all important patient information prior to your patient's appointment to better serve their health needs.

It is our policy to obtain written assurance that there are no medical contraindications to hearing aid use. Please complete the statement below in the event we determine that your patient is a candidate for amplification.

There are no medical contraindications Right________ Left________

Yes, there are medical contraindications Right________ Left________
Please explain:____

Date of medical evaluation: __________________ **Physician's Signature** ______________________________