Andwell
Audiology

Audiology Referral

Date:

Patient Name:

Date of Birth:

Primary diagnosis:

Patient is being referred to Audiology for the following (mark referrals reason(s) with an "X"):

- ☐ Hearing loss evaluation and treatment
- ☐ Tinnitus management
- ☐ Chronic ear infections or other ear disorder
- ☐ Hearing aid fitting, assistance, repair, cleaning
- ☐ Newborn hearing evaluation
- ☐ Other _____

Please include the patient's demographics, most recent medical history, visit notes detailing hearing health concerns, and any previous hearing test results.

☐ My patient and/or guardian/family are aware of this referral.

Provider Signature: _____ Date: _____

Provider Name (printed): _____ Phone: _____

Note(s):

Sent By: _____ Phone Number: _____

Please fax completed form to:
Attn: Patient Services Center at 207-307-2668
Questions? – Contact Andwell Audiology at 207-777-7740