AUDIOLOGY SERVICES

Scheduling Line: (714) 639-4991 **Fax: (714) 744-3841**

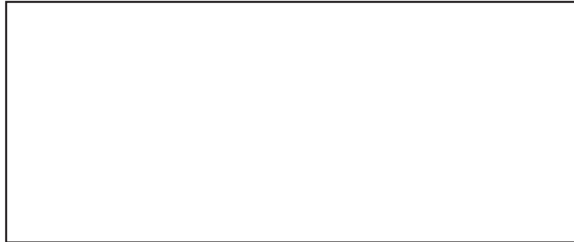
Thank you for referring your patient to Providence Speech and Hearing Center. To better serve you and your patient, please provide us with the following information via fax:

Patient Name: ________________________________ **Date of Birth:** ________________________________

ICD 10/Chief Complaint/Reason for Referral: ____

Patient has been medically evaluated and considered a candidate for Hearing aid(s)/ non-implanted osseointegrated Device.

Physician Stamp: (Otolaryngologist/Ear Nose and Throat Physician)



Patient is medically cleared for hearing aid/non-implant bone conduction device use.

Physician Signature: ____ **Date:** ____________________

(Otolaryngologist/Ear Nose and Throat physician)