

Medical Practitioner Hearing Check Referral



Electronic version available at audika.com.au/refer-a-patient

Patient information:

Title:

First name:

Surname:

Details of referring Medical Practitioner:

Title

First name:

Surname:

Medicare Provider Number:

Medical Practitioner Stamp:

(Must include Medicare provider number)

Address:

State: Postcode:

Telephone Number:

()

Email Address:

Appointment type:

Full Hearing Assessment (audiogram) Hearing Aids Pre-employment check

Other (please specify) _____

Certification by Medical Practitioner:

I have examined this patient and (tick as appropriate)

I am satisfied that there are no medical contraindications to the fitting of a hearing device **OR**

I consider that there are medical contraindications to the fitting of a hearing device

Medical Practitioner's Signature: (Please print referral form to sign and date below)

_____ Date: / /

Once completed by your Medical Practitioner simply call **1800 753 164** to book a consultation and to discuss our fully government subsidised* hearing tests. Please bring this completed form with you on or before the date of your appointment.

*Conditions apply to clients under the Australian Government Hearing Services Program. Applies to adults over 26 years only. Audika values your personal information in accordance with our privacy policy. Visit www.audika.com.au/privacy-policy for more information.

audika.com.au