AUSTRALIAN HEARING CARE
LET'S HEAR, LET'S CONNECT

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Patient Referral Form

Patient Name: DOB:

Address:

Telephone: Email:

Pension No./ DVA No./ Private Health Fund:

Doctor Details

Referring Doctor:

Address:

Telephone:

Reason For Referral

- ☐ Complete Hearing Assessments
- ☐ DVA Assessments
- ☐ Middle Ear Function Test
- ☐ Hearing Aid Evalution
- ☐ Hearing Aid Programming/ Repair
- ☐ Tinnitus Assessments
- ☐ Pre-employment Hearing Tests
- ☐ Commercial Licence Test
- ☐ Hearing Aid Battery
- ☐ Ear Moulds
- ☐ Ear Plugs (Noise,Musician and Swimming)
- ☐ Other _____