PHYSICIAN REFERRAL FORM

PATIENT INFORMATION

Patient Name: ______________________________ Patient Phone: ______________

Diagnosis: ____

PATIENT SYMPTOMS/REPORT

- ☐ HEARING LOSS, BILATERAL
- ☐ HEARING LOSS, UNILATERAL [R or L]
- ☐ SUDDEN HEARING LOSS
- ☐ VERTIGO/DIZZINESS
- ☐ HEARING PROTECTION
- ☐ TINNITUS

ADDITIONAL INFORMATION

SPECIFIC ORDERS/COMMENTS: ____

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REFERRING PROVIDER INFORMATION

PHYSICIAN: ____

PHYSICIAN SIGNATURE: ____

DATE: ____

REFERRAL CLINIC

3017 TELEGRAPH AVE. STE. 230 BERKELEY, CA 94705

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