

*Attach patient label here if available*

Name: _____	
Address: _____	
Phone: _____	Date of Birth: _____

### Referred for:

- |  |  |
|--|--|
| <input type="checkbox"/> Free hearing screening              | <input type="checkbox"/> Custom ear plugs                    |
| <input type="checkbox"/> Adult diagnostic hearing assessment | <input type="checkbox"/> Wax removal                         |
| <input type="checkbox"/> Hearing aid assessment and fitting  | <input type="checkbox"/> Cochlear implant assessment         |
| <input type="checkbox"/> Tinnitus/Hyperacusis assessment     | <input type="checkbox"/> High-frequency audiometry           |
| <input type="checkbox"/> Child hearing testing (age: _____ ) | <input type="checkbox"/> Balance testing (Christchurch only) |
| <input type="checkbox"/> Auditory Processing testing (7+yrs) | <input type="checkbox"/> Other                               |

Comments: *e.g. relevant patient history, reason for referral*

Doctor's Stamp: