Chester Heights
Hearing Aid Center, LLC

MEDICAL REFERRAL

REFERRED TO:

Physician _____

Address _____

City _____ State _____ Zip _____ Phone _____

PATIENT REFERRED:

Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

REASON FOR REFERRAL:

_____ 1. Deformity of the ear

_____ 2. Drainage

_____ 3. Sudden or progressive hearing loss

_____ 4. Acute or chronic dizziness

_____ 5. Pain or discomfort in ear: **AD** **AS** **AU**

_____ 6. Unilateral hearing loss: **SUDDEN** **RECENT** **ONSET (90 DAYS)**

_____ 7. Air/Bone gap greater than 15dB @ 500Hz, 1000 Hz, +2000 Hz

_____ 8. Cerumen accumulation or foreign body in ear canal: **AD** **AS** **AU**

_____ 9. Asymmetrical hearing loss: **AD** **AS**

_____ 10. Medical clearance for hearing aid candidacy

_____ 11. 0ther _____

Dispenser _____

Richard P. Claffey, BC, HIS

The above patient has been medically evaluated and may be considered a candidate for a hearing aid(s).

Physician's signature _____ Date _____

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