CEID Audiology

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AUDIOLOGICAL REFERRAL FORM

TO BE COMPLETED BY PHYSICIAN

FAX OR EMAIL FORM TO:
510-373-6528
audiology@ceid.org

Patient: _____ Date of Referral: _____

Date of Birth: _____ Parents Name: _____

Physician: _____ Home Address: _____

Hospital/Clinic: _____ City: _____

Physician Contact/Phone #: _____ Home Phone: _____

MEDICAL INFORMATION

Reason (s) for Referral: _____

Relevant Medical History: _____

CURRENT HEALTH STATUS

Present Concerns/diagnosis*/illness; ICD-9 code: _____

Hospitalization/Surgeries: _____

Current Medications/Medical Precautions: _____

Hearing Status: _____ Date Screened: _____ Results: _____

Other Referrals made/Additional Comments: _____

Physician Signature: _____ Date: _____

INSURANCE INFORMATION

***** Must attach copy of current medical insurance card (s) ****

Primary Insurance Carrier: _____ Insurance ID#: _____

Secondary Insurance Carrier: _____ Insurance ID #: _____

Subscriber's Name: _____ Subscriber's ID #: _____

MEDI-CAL PATIENTS ID #: _____ Issue Date on card: _____

Parents: Please take this form to your Primary Care Physician for referral.