University Medical Center Brackenridge

Specialty Clinics

Adult Audiology Request Form

Phone: 512-324-9999 x77826

Fax: 512-380-7508

Please COMPLETE this updated Physician Order form for ADULT audiology referrals

> Please include a demographics sheet,

& please encourage your patients to show up for their appointments

Requesting: *D* ***Basic Audio*** *D* ***Other*** _____

THIS VISIT

FROM: _____

D REQUIRES AUTHORIZATION

PHONE: _____ *Authorization #:*

FAX: _____ *D DOES NOT REQUIRE AUTHORIZATION*

******Referrals without a fax number will be rejected******

(Must be)

Full Name of Referring Physician: _____ *M.D. or D.O.*

Name of Patient's PCP: _____

Diagnosis/Reason for Referral (Check ALL that apply):

D Decreased hearing *D Otitis/inflammation of ear* *D Speech delay*

D Unilateral/asymmetric loss *D TM perforation* *D Tinnitus*

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D Sudden hearing loss *D Discharge from ear* *D Adverse affects of medication*

D Vertigo/dizziness *D Ear Pain* *D Other*_____

Patient name:_____***Date of birth***_____/ / _____

_____

*Contact Numbers:*_____

*Insurance Company:*_____*Group or ID#:*_____

X_____***Date:***_____

Physician Signature and Date Required