

THE UNIVERSITY OF TENNESSEE HEARING & SPEECH CENTER
CHILD HEARING SERVICES
545 SOUTH STADIUM HALL
KNOXVILLE, TN 37996-2500
TEL: 865-974-1788 FAX: 865-974-1539
BOOKKEEPER TEL: 865-974-4633

Patient's Name: _____ Birthdate _____ Sex _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work)

Parent/Spouse/Legal Guardian: _____

1. Purpose of Referral (Please check those that apply)

Aural habilitation -pre-lingual Eval _____ Aural habilitation - post lingual Eval _____
Auditory Processing Test _____ Pre/Post Cochlear implant Eval. _____
Aural habilitation therapy _____ Aural rehabilitation therapy _____

2. Pertinent Medical History and/or Diagnosis:

3. Please list name of Insurance Carrier: _____
Subscriber ID#: _____ Group #: _____
Does the insurance carrier require a pre-cert or authorization number? _____
If so, PLEASE FAX TO OUR OFFICE BEFORE THE APPT. DATE OR INCLUDE
HERE. Pre-cert or authorization # _____ number of visits _____
dates visits are valid _____.
If patient has BlueCare/TennCare Select, physician's provider number _____.

4. If applicable, list name and phone number of Primary Care Physician:

(Name) (Phone)

5. Additional Comments:

PLEASE include physician's UPIN AND NPI _____.
Referring Physician: _____ Phone: _____
(Please print or type)

Signature of Physician: _____ Date: _____

Address: _____

Revised 01/2007

THE UNIVERSITY OF TENNESSEE HEARING & SPEECH CENTER
1600 PEYTON MANNING PASS
KNOXVILLE, TN 37996-2500
SPEECH-LANGUAGE SERVICES : TEL: 865-974-5451 FAX: 865-974-4639
SPEECH-LANGUAGE REFERRAL FORM

Patient's Name: _____ Birthdate _____ Sex _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work) (Cell)

Parent/Spouse/Legal Guardian: _____

1. Purpose of Referral (Please check those that apply)

Speech-Language Evaluation & Treatment _____
Concern: Unclear speech _____ Delayed language _____ Fluency _____
Aphasia _____ Voice _____
Other _____

2. Pertinent Medical History and/or Diagnosis:

3. Please list name of Insurance Carrier: _____

Subscriber ID#: _____ Group #: _____

Does the insurance carrier require a pre-cert or authorization number? _____

If so, PLEASE FAX TO OUR OFFICE BEFORE THE APPT. DATE OR INCLUDE

HERE. Pre-cert or authorization # _____ number of visits _____

dates visits are valid _____.

If patient has BlueCare/TennCare Select, Include physician's provider # _____

PLEASE include physician's UPIN AND NPI _____

4. If applicable, list name and phone number of Primary Care Physician:

(Name) (Phone)

5. Additional Comments:

Referring Physician: _____ Phone: _____
(Please print or type)

Signature of Physician: _____ Date: _____

Address: _____

THE UNIVERSITY OF TENNESSEE HEARING & SPEECH CENTER
1600 PEYTON MANNING PASS
KNOXVILLE, TN 37996-2500
SPEECH-LANGUAGE SERVICES : TEL: 865-974-5451 FAX: 865-974-4639
SPEECH-LANGUAGE REFERRAL FORM

Patient's Name: _____ Birthdate _____ Sex _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work) (Cell)

Parent/Spouse/Legal Guardian: _____

1. Purpose of Referral (Please check those that apply)

Speech-Language Evaluation & Treatment _____
Concern: Unclear speech _____ Delayed language _____ Fluency _____
Aphasia _____ Voice _____
Other _____

2. Pertinent Medical History and/or Diagnosis:

3. Please list name of Insurance Carrier: _____

Subscriber ID#: _____ Group #: _____

Does the insurance carrier require a pre-cert or authorization number? _____

If so, PLEASE FAX TO OUR OFFICE BEFORE THE APPT. DATE OR INCLUDE

HERE. Pre-cert or authorization # _____ number of visits _____

dates visits are valid _____.

If patient has BlueCare/TennCare Select, Include physician's provider # _____

PLEASE include physician's UPIN AND NPI _____

4. If applicable, list name and phone number of Primary Care Physician:

(Name) (Phone)

5. Additional Comments:

Referring Physician: _____ Phone: _____
(Please print or type)

Signature of Physician: _____ Date: _____

Address: _____

THE UNIVERSITY OF TENNESSEE HEARING & SPEECH CENTER
457 SOUTH STADIUM HALL
KNOXVILLE, TN 37996-0740
TEL: 865-974-5453 FAX: 865-974-1792
REFERRAL FORM

Patient's Name: _____ DOB _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work) (Cell)

Parent/Spouse/Guardian: _____

1. Is audiological diagnostic information needed in order to assist with the decisions regarding additional medical treatment? _____ Yes _____ No

2. Purpose of referral:

- Adult Hearing Evaluation
- Pediatric Hearing Evaluation
- Amplification Evaluation
- Auditory Processing Evaluation
- Neurological Auditory Brainstem Response Evaluation (ABR)
- Threshold Auditory Brainstem Response Evaluation (ABR)
- Electrocochleography (EcochG)
- Electro-stagmography (ENG)

3. Pertinent Medical History and/or Diagnosis:

4. Please list name of Insurance Carrier: _____
Subscriber ID# _____ Group # _____
Does the insurance carrier require a **pre-cert or authorization number**? _____
If so, Pre-cert or authorization # _____ # of visits _____
If patient has BlueCare/TNCare Select, include **physician's provider #** _____
Please include **physician's UPIN and NPI numbers** _____

5. Medical Clearance: Is there any medical basis to contraindicate the use of a hearing aid?
_____ Yes _____ No

Referring Physician: _____ Phone: _____
(Please print or type)

Signature of Physician: _____ Date: _____

Address: _____