THE UNIVERSITY of TENNESSEE UT
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

Audiology Clinic (UTK Campus)
455 South Stadium Hall
Knoxville, TN 37996-0740
Phone: 865-974-5453
FAX: 865-974-1792

NEW PATIENT REFERRAL FORM - *AUDIOLOGY*

Revised 6/2018

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________ Male/Female

Parent/Spouse/Guardian: ______________________________

Address: ______________________________City: ______________State: ___Zip: ___________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

CHIEF COMPLAINT and/or DIAGNOSIS (i.e. hearing loss, tinnitus, dizziness)

List all that apply including associated ICD-10 Code(s): ______________________________

MEDICAL CLEARANCE: Is there any medical basis to contraindicate the use of hearing aids if the patient meets candidacy? Yes _______ No _______

PURPOSE OF REFERRAL: (*Check all appropriate*)

[ ] Adult Hearing Evaluation
[ ] Cerumen Management
[ ] Pediatric Hearing Evaluation (including a speech-language evaluation, if indicated)
[ ] Amplification Evaluation
[ ] Auditory Processing Evaluation - Age 7 & Older (including a speech-language evaluation, if indicated)
[ ] Dizziness Clinic Evaluation (New evaluations may consist of 1-3 visits)
[ ] Tinnitus Evaluation (including a Hearing Evaluation, if indicated) Tinnitus is: [ ] constant [ ] intermittent
[ ] Unilateral Hearing Loss Evaluation (including spatial hearing evaluation)
[ ] Neurological Auditory Brainstem Response Evaluation (ABR)
[ ] Threshold Auditory Brainstem Response Evaluation (ABR) and/or Pediatric Hearing Evaluation
[ ] Electrocochleography (ECochG)
[ ] Cochlear Implant Programming
[ ] Cochlear Implant Assessment (Pre/Post) including Dizziness Clinic Evaluation Date of CI surgery: ______________
[ ] Aural Oral Evaluation/Speech-Language Evaluation [ ] Aural Re/Habilitation (Speech) Therapy

PLEASE NOTE:
This referral is effective for **one year** from the date received.
Our Center will send requests to update referrals on established patients.

PROVIDER INFORMATION

Referring Physician: ______________________________

Address: ______________________________

Phone #: ______________Fax #: ______________

Provider's NPI:______________________________

Primary Care Provider: ______________________________

Phone #: ______________Fax #: ______________

Provider's NPI: ______________________________

- **Before we can schedule your patient and bill for insurance we must have the referring provider's NPI.**
- **Please also send *all* relevant medical notes or test results**

Is this patient currently receiving home healthcare services?

[ ] No [ ] Yes List provider ______________________________

INSURANCE INFORMATION

Insurance Carrier:______________________________

Medicare? Yes/No Supplemental? Yes/No TennCare? Yes/No

Subscriber ID#: ______________ Group #: ______________

Is a **pre-cert or authorization number Required**? Yes or No

Authorization/pre-cert #: ______________# of visits: _______

AND

- **Send a copy of the patient's insurance card (front and back)**

Referring Provider's Signature (required for patients 21 years and under): ______________________________ **Date:** ______________