THE UNIVERSITY of TENNESSEE 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

PATIENT REFERRAL FORM - *AUDIOLOGY*

Revised 8/2019

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 and/or vestibular evaluation, if indicated)
[ ] Amplification Evaluation (including a speech-language and/or vestibular evaluation, if indicated)
[ ] 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 established patients **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:** _____