Medical Order for Audiology Services

Patient name: _____

Birthdate: _____

Patient is referred for audiological evaluation due to medical need as indicated below:
(Please check any/all that apply)

___ C/o hearing loss/deficit/impairment/disorder

___ Observed/reported hearing difficulty

___ Failed hearing screening

___ C/o or history of tinnitus/ringing/noises in the ear

___C/o dizziness/vertigo/disequilibrium/imbalance

___ Recent fall and/or imbalance episode

___ History/question of Meniere's disease

___ C/o ear pain/discomfort/fullness

___ C/o blocked ear(s)

___ History or observation of cerumen impaction

___ History of outer ear pathology

___ History of middle ear pathology

___ Observed drainage from ear(s)

___ Trauma/injury to ear/head

___ History of stroke/TIA

___ History of meningitis

___History of diabetes

___ History/question of treatment with ototoxic medications

___ Change in patient's behavior/responsiveness

___ Decreased participation in activities

___ Decreased social interaction

___ Withdrawal/non-responsive behavior

___ Other_____

_____

_____

*__IMPORTANT:__ Please attach documentation and verification of current medications in the patient's medical record. (including prescriptions, OTC, herbals, vitamin/mineral/dietary, (nutritional) supplements including drug name, frequency and route.

Ordered by: _____ NPI: _____
(Please print)
Address: _____
Phone: _____ Fax: _____
Signature: _____
Date of Order: _____

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