

## Referral Form

Patient's name: \_\_\_\_\_

Patient's Phone #: \_\_\_\_\_

Referral for: ☐ Comprehensive Hearing Testing  
☐ Electronystagmography Testing  
☐ Physical Therapy Evaluation

### Indication:

- |   |  |
|---|--|
| <input type="checkbox"/> 279.4 Autoimmune disease, not elsewhere classified           | <input type="checkbox"/> 388.43 Impairment of auditory discrimination      |
| <input type="checkbox"/> 381.10 Chronic serous otitis media, simple or unspecified    | <input type="checkbox"/> 388.44 Recruitment                                |
| <input type="checkbox"/> 381.81 Dysfunction of Eustachian tube                        | <input type="checkbox"/> 388.60 Otorrhoea, unspecified                     |
| <input type="checkbox"/> 384.2 Perforation of tympanic membrane                       | <input type="checkbox"/> 388.70 Otalgia, unspecified                       |
| <input type="checkbox"/> 385.3 Cholesteatoma of middle ear and mastoid                | <input type="checkbox"/> 389.0 Conductive deafness                         |
| <input type="checkbox"/> 386.0 Ménière's disease                                      | <input type="checkbox"/> 389.08 Conductive deafness of combined types      |
| <input type="checkbox"/> 386.10 Peripheral vertigo, unspecified                       | <input type="checkbox"/> 389.10 Sensorineural deafness, unspecified        |
| <input type="checkbox"/> 386.11 Benign paroxysmal positional vertigo                  | <input type="checkbox"/> 389.11 Sensory deafness                           |
| <input type="checkbox"/> 386.19 Other peripheral vertigo                              | <input type="checkbox"/> 389.12 Neural deafness                            |
| <input type="checkbox"/> 386.3 Labyrinthitis  | <input type="checkbox"/> 389.14 Central deafness                           |
| <input type="checkbox"/> 386.9 Unsp. vertiginous syndromes and labyrinthine disorders | <input type="checkbox"/> 389.18 Sensorineural deafness of combined types   |
| <input type="checkbox"/> 387.9 Otosclerosis, unspecified                              | <input type="checkbox"/> 389.2 Mixed conductive and sensorineural deafness |
| <input type="checkbox"/> 388.01 Presbycusis   | <input type="checkbox"/> 389.8 Other specified forms of deafness           |
| <input type="checkbox"/> 388.11 Acoustic trauma (explosive) to ear                    | <input type="checkbox"/> 780.4 Dizziness and giddiness                     |
| <input type="checkbox"/> 388.2 Sudden hearing loss, unspecified                       | <input type="checkbox"/> 781.2 Abnormality of gait                         |
| <input type="checkbox"/> 388.30 Tinnitus, unspecified                                 | <input type="checkbox"/> 781.3 Lack of coordination                        |

Other: \_\_\_\_\_

Provider's name: \_\_\_\_\_ UPIN: \_\_\_\_\_

Practice name: \_\_\_\_\_

Practice phone #: \_\_\_\_\_

Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FAX SIGNED FORM TO**