



Please **fax** signed referral to Easter Seals Central Texas

A copy of this form, signed by the referring physician (MD or DO). Patients under age of 18 years requires a referral from an ENT specialist for initial evaluation.

Audiology

(Audiology services for children and adults of all ages.)

8505 CROSS PARK DR. STE 120, Austin, Texas 78754

Phone: 512.615.6843

Fax: 512.476.1638

Client Information

Client Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:	City:	Zip:
Email address:		
Parent's/ Guardian Full Name:		
Home Phone:	Work Phone:	
<input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> Spanish Speaking <input type="checkbox"/> Other Language		

Treatment Disciplines (please select):	<input checked="" type="checkbox"/> Audiology	
<input type="checkbox"/> H90.2 Conductive Hearing Loss, unspecified <input type="checkbox"/> H91.90 Unspecified Hearing Loss, unspecified ear <input type="checkbox"/> H91.91 Unspecified Hearing Loss, right ear <input type="checkbox"/> H91.92 Unspecified Hearing Loss, left ear <input type="checkbox"/> H91.93 Unspecified Hearing Loss, bilateral	<input type="checkbox"/> Other (Please list):	

Health Care Provider Information			
Ordering Physician (MD or DO):		Primary Care Physician/Practice:	
Address:		Fax:	
Phone:	UPIN #:	NPI #:	
Physician Full Name (printed):			
Physician Signature: _____ *** Note: Physician (MD or DO) signature required ***			Date:

Form updated: 4/11/2017

Please call **512.615.6843** for more information, or visit us at www.centraltx.easterseals.com