hearing aids
Karen Scott Au.D.
audiology

3220 South Higuera Street
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Phone (805) 541-1790
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Quick Referral Fax Sheet

Please complete form and fax with all information below

To: Karen Scott Audiology

Fax # 805-541-1793

From: ______________________ (Referring Physician's Name)

______________________ (NPI #)

(   ) ______________________ (Physician's Phone #)

(   ) ______________________ (Physician's Fax #)

Patient's Name: ______________________

(   ) ______________________ (Patient's Phone #)

______________________ (D.O.B)

______________________ (Contact Person or Guardian, if patient is a child)

(   ) ______________________ (Contact Phone #)

- ☐ I prefer **Karen Scott Audiology** contact the patient directly to schedule appointment.
- ☐ The patient will call **Karen Scott Audiology** to schedule appointment.

Requested Services:

- ☐ Evaluate & Treat Hearing Loss
- ☐ **Medical Clearance:** I have evaluated this patient and find no medical reason a hearing aid should not be used in correcting any hearing loss.
- ☐ Evaluate & Treat Tinnitus
- ☐ **Medical Clearance:** I have evaluated this patient and find no medical reason a hearing aid/sound generator should not be used in correcting this patient's tinnitus.
- ☐ Evaluate Middle Ear Function
- ☐ Custom Hearing Protection
- ☐ Custom Swim Plugs
- ☐ Other ______________________

Instructions & Special Requirements: ______________________

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I certify that all requested services are medically necessary for this patient's plan of care.

______________________ (Physician's Signature)

______________________ (Date)

Revised 9/11