Physician/Hearing Specialist Referral Report

Name: ___________________________ Date: ____________________________

School: ___________________________

Results of Threshold Hearing Test

Right Ear						Left Ear					
250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000

PASS ☐
FAIL ☐

Provider Audiogram Attached? ☐ YES ☐ NO

Tentative Diagnosis: ____

Type of Hearing Loss: ____

Prognosis: ____

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Recommendations:

1. ____
2. ____
3. ____

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Physicians Signature

____
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Physician's Address/Phone