Kos/Danchak
AUDIOLOGY & HEARING AIDS

Patient Information

Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Diagnosis Code: ______________________________

Referring Physician Information

Physician: ______________________________

Practice: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

Fax: ______________________________

Please check the tests that are being ordered below:

☐ **Full Battery—**Routine test battery includes Audiometry, Otoacoustic Emission testing and Immittance testing.

If Full Battery is not desired, please select individual test orders below:

- ☐ **Cognivue—**Cognitive Testing
- ☐ **Audiometry/OAE/Immittance—**Conventional behavioral hearing evaluation to assess hearing sensitivity, middle ear function and outer hair cell function
- ☐ **Tinnitus Evaluation—**Hearing evaluation and Tinnitus assessment

Notes: ______________________________

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Physician Signature: ______________________________ Date: ______________

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