LAKESIDE AUDIOLOGY
Hearing Solutions for All

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FORT MILL, SC 29708
803.620.8250 (phone)
1.803.638.6901 (fax)

REFERRAL FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ / _____ / _____

Gender: ☐ Male ☐ Female Parent/Guardian Name (if < 18):_____

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____

Email: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Insurance Carrier: _____ Policy / Medicaid #: _____

REASON FOR REFERRAL:

- ☐ Failed hearing screening / Suspected Hearing Loss
- ☐ Known hearing loss / continuation of care
- ☐ Newborn hearing screening
- ☐ Speech delay
- ☐ Tinnitus or other otologic symptom
- ☐ Ototoxic monitoring
- ☐ Other: _____

REFERRAL SOURCE:

Referring Location/Provider: _____

Referral Contact: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

PHYSICIAN / SPECIALIST SIGNATURE: _____ Date: _____

Printed Name: _____

PLEASE ATTACH A COPY OF THE PATIENT'S CURRENT MEDICATION LIST AND PHYSICIAN'S MOST RECENT ENCOUNTER WITH THIS PATIENT. EXAMPLES MAY INCLUDE:

- **OFFICE PROGRESS NOTE**
- **MEDICAL HISTORY**

FAX TO: 1.803.638.6901