

APPOINTMENT

Clinic Date Time

REFERRAL FORM

ENT Consultants	Dr P. Allison Dr J. Blaszczyk Dr M. Busby Dr P. Canty	Dr S. Coman Prof W. Coman Dr M. Courtney Dr D. Cronin	Dr G. Fitzgerald Dr R. Grigg Dr J. Hallam Dr R. Harrington	Dr S. Kelly Dr D. McCrystal Dr B. McMonagle Dr J. O'Neill	Dr B. Panizza Dr F. Panizza Dr A. Parker Dr C. Perry	Dr C. Que Hee Dr A. Sprague Dr B. Wallwork Dr R. Wilson
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PATIENT'S DETAILS

Surname _____ First Name _____

Address _____

Phone (H) _____ (M) _____ DOB _____

CLINICAL HISTORY

GENERAL TESTING

- Hearing Test
 - Medicolegal
- Hearing Aid Assessment
- Tinnitus Consultation
 - Tinnitus Management Program
(Neuromonics Tinnitus Treatment)
- Pre-Employment Hearing Test
- Auditory Processing Assessment (>6 years)
- Balance Test (VNG/ENG and calorics)
 - VEMP
- Auditory Brainstem Response (ABR)
- Otoacoustic Emissions

EAR AND HEARING PROTECTION

- Custom Swim Plugs
- Custom Noise Plugs
- Custom Musician Plugs
- Custom fit MP3 earbuds

FURTHER TESTING

- Electrocochleography, *extratympanic* (ECOG)
 - Fistula test
- Cortical Evoked Responses (CERA)
- Late Cortical Responses (P300)
- Facial Nerve Test (ENOG) *Brisbane only*
- Cochlear Implant Assessment
 - Advanced Speech Tests
- Bone Anchored Hearing Aid (BAHA) assessment
- Other *(please specify below)*

REFERRING DOCTOR

Provider No _____ Report to _____
(Stamp)

Signature _____ Date _____

Results requested by: Post Fax Fax and Post

Brisbane Metropolitan

Brisbane

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Brisbane QLD 4000

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Gold Coast/ Northern NSW

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E ashmore@qha.com.au

Southport

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Toowoomba

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Sunshine Coast

Sunshine Coast

Minyama

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