Bay Audiology
Medical Referral Form

Patient details:

Patient name: ____________ Patient DOB: ____________

Patient address: ____________

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Patient contact number: ____________

Patient email: ____________

Referral reason (please tick the applicable box):

- [ ] Full diagnostic hearing test
- [ ] Hearing aid needs assessment and discussion
- [ ] Tinnitus evaluation and counselling

Other: ____________

Notes: ____________

Report method:

- [ ] Post
- [ ] Email

Referrer details:

Doctor name: ____________ Practice name: ____________

Practice address: ____________

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Contact number: ____________

Email: ____________

For every patient you refer to us we will provide a timely hearing test report, including an audiogram. We will also inform you if your patient has been fitted with hearing aids so that you know exactly what treatment your patient has received.

Send to us via:
Email: nzrecall@bayaudiology.co.nz
Post: PO BOX 100260 North Shore, Auckland 0745