

# AUDIOLOGY REFERRAL



## Patient Details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ D.O.B: \_\_\_\_\_

**Chronic Disease Management (CDM) referral for Hearing Assessment (Bulk Billed)**  
*Please attach CDM Referral Form*

## Referred for:

- |   |  |
|---|--|
| <input type="checkbox"/> Hearing Assessment   | <input type="checkbox"/> Pre-employment Hearing Test |
| <input type="checkbox"/> Hearing Assessment (Pension Concession Card / Department of Veteran Affairs) | <input type="checkbox"/> Aviation Hearing Test       |
| <input type="checkbox"/> Hearing Aids   | <input type="checkbox"/> Police Hearing Test         |
| <input type="checkbox"/> Custom Ear Plugs   | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> WorkSafe Assessment  | _____  |
|   | _____  |

## Referring Doctor:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please call (03) 8510 0535 to book an appointment.**

Phone/Fax: (03) 8510 0535  
Email: [admin@quantumhearing.com.au](mailto:admin@quantumhearing.com.au)  
[www.quantumhearing.com.au](http://www.quantumhearing.com.au)



**Wheelers Hill Shopping Centre: Shop 27, 190 Jells Road, Wheelers Hill, Victoria, 3150**