PERTH EAR HEALTH

ADVANCED EAR & HEARING CARE

Name: _____ DOB: _____ /_____ / _____

Phone: _____ Email: _____

## Reason For Referral - Tick All That Apply

□ Hearing assessment – adult

□ Hearing assessment – paediatric (≥4 years)

□ Hearing aid review / optimisation

□ Cochlear implant / implantable hearing device pathway

□ Middle ear disease

□ Otitis externa / otomycosis management

□ Cerumen management (microsuction)

□ Tinnitus assessment & counselling

□ Sudden hearing loss (urgent)

## Appointment Priority

□ Routine

□ Moderate priority

□ Urgent

## Referring Clincian

Name: _____ Provider No: _____

Practice: _____ Email: _____

Phone: _____ Signature: _____

**Clearer Hearing Starts Here**