

Patients Details

Full Name *

Address *

Email

Phone Number *

Tests Required

- Diagnostic Hearing assessment
- Hearing aid evaluation
- Tinnitus assessment/management
- Custom ear-plugs for swimming/music/noise
- Other _____

Medical Certificate for Hearing Services *

I hereby certify that there are no medical contraindications for a hearing-aid fitting for this patient.

Date *

Signature *

MEDICAL PRACTITIONER STAMP *

(Must include Medicare Provider Number)