

PATIENT DETAILS

Family Name

Given Name/s

Date of Birth (dd/mm/yyyy)

Contact Number

AUDIOLOGICAL ASSESSMENT / REHABILITATION

☐ Please tick if there are contraindications to fitting of hearing devices

☐ Adult Hearing Assessment & Rehabilitation,
where appropriate

☐ Auditory Processing Assessment *
(age 6 and up)

☐ Paediatric Hearing Assessment (age 3 and up)

☐ Tinnitus Consultation

☐ Bone Conduction Implant Assessment /
Management

☐ Ear Toilet *
(micro-suction or curettage)

☐ Cochlear Implant Assessment /
Management

* currently not available at Cairns clinic

CLINICAL HISTORY

MEDICAL PRACTITIONER CERTIFICATION

Medical Practitioner Name

Stamp

Medical Provider Number

Contact Number

Medical Practitioner Signature

Date