# AUDIOLOGY SERVICES

**Scheduling Line: (714) 639-4990** **Fax: (714) 744-3841**

Thank you for referring your patient to Rady Children's Restorative Care. To better serve you and your patient, please provide us with the following information via fax:

**Patient Name:** _____ **Date of Birth:** _____

**ICD 10/Chief Complaint/Reason for Referral:** _____

Patient has been medically evaluated and considered a candidate for hearing aid(s)/ non-implanted osseointegrated device.

**Physician Stamp:** (Otolaryngologist/Ear Nose and Throat Physician)

## Patient is medically cleared for hearing aid/non-implant bone conduction device use.

**Physician Signature:** _____ **Date:** _____

(Otolaryngologist/Ear Nose and Throat physician)