



## Referral for Audiology Services

Name:

Address:

Phone:

Email:

[www.theaudiologyproject.com/hearscreenusa](http://www.theaudiologyproject.com/hearscreenusa) \_\_\_pass \_\_\_fail

### AT RISK MEDICAL FACTORS FOR HEARING LOSS

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Allergies/sinus         | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Renal problems           | <input type="checkbox"/> Cardiovascular problems | <input type="checkbox"/> Noise exposure           |
| <input type="checkbox"/> Hypothyroidism           | <input type="checkbox"/> Pain in ears            | <input type="checkbox"/> Sudden change in hearing |
| <input type="checkbox"/> Tinnitus                 | <input type="checkbox"/> Head trauma             | <input type="checkbox"/> Dizziness/vertigo        |
| <input type="checkbox"/> Complaint of not hearing | <input type="checkbox"/> Genetic/family history  | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Other _____              |  |   |

### AT RISK MEDICATIONS FOR HEARING LOSS

### OTOTOXIC MONITORING REQUEST:

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Aminoglycoside antibiotics  | <input type="checkbox"/> baseline |
| <input type="checkbox"/> Loop diuretics              | <input type="checkbox"/> 1 month  |
| <input type="checkbox"/> Cancer chemotherapy         | <input type="checkbox"/> 3 months |
| <input type="checkbox"/> Salicylate analgesics       | <input type="checkbox"/> 6 months |
| <input type="checkbox"/> Hormone replacement therapy |                                   |
| <input type="checkbox"/> Other _____                 |                                   |

Order: EVALUATE HEARING FOR MEDICAL MANAGEMENT PURPOSES

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Signature (MD, DO, NP)

Print Name

Date

NPI



North Carolina Building Our Largest  
Dementia (NC BOLD) Infrastructure Project