AudioClinic™
Hear in full colour

Medical Practitioner Clearance Form

For an electronic version of this form visit audioclinic.com.au/refer-a-patient or call your local clinic on 1800 057 220

Patient Information:

Title: First Name: Surname:

Details of referring Medical Practitioner:

Title: First Name: Surname:

Medicare Provider Number:

Address:

State: Postcode:

Telephone Number:

( )

Certification by Medical Practitioner:
I have examined this patient and (tick as appropriate):

☐ I am satisfied that there are no medical contraindications to the fitting of a hearing device.

OR

☐ I consider that there are medical contraindications to the fitting of a hearing device.

Medical Practitioner's Signature:
(Please print referral form to sign and date below).

Date: / /

Once completed by your Medical Practitioner, simply call your local AudioClinic to talk about your FREE* hearing consultation today.

Freecall 1800 057 220 or visit **audioclinic.com.au**

*Applies to adults over 26 years only.