REFERRAL FORM

Please complete the following information should you refer to

Constance Brown Hearing Centers

Date of Referral _____ **Phone Number** _____

Contact Name _____ **Practice** _____

Referring Physician _____ **Fax Number** _____

PATIENT INFORMATION

Patient Name _____ **Parent Name (if Child)** _____

Date of Birth _____ **Guardian Name** _____

Address _____

City _____ **State** _____ **Zip** _____

Primary Phone _____ **Secondary Phone** _____

Email Address _____

Reason for Referral _____

INSURANCE INFORMATION or send a copy of the insurance card(s)

Primary Insurance _____

Contract # _____ **Group #** _____

Policyholder _____ **Policy Holder DOB** _____

Secondary Insurance _____

Contract # _____ **Group #** _____

Policyholder _____ **Policy Holder DOB** _____

☐ **Copy of insurance card(s)**

PLEASE FAX COMPLETED FORM AND ANY <u>PERTINENT</u> HEALTH INFORMATION INCLUDING LIST OF MEDICATIONS TO (269) 343-9257

If preferred, call (269) 343-2601 to speak with someone directly about scheduling an appointment for your patient.

For office use only:

Appointment Date _____ Audiologist _____

Appointment Time _____ Date Paperwork Sent _____

Appointment Location: Kalamazoo Portage

Revised 5/1/2018