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 PERTINENT 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 CBHC # ________________

Revised 2.15.2022