



SERVICE REQUEST FORM

PLEASE FILL OUT THE FORM AND FAX TO 602.406.7175
PLEASE FAX A COPY OF INSURANCE CARD(S) WITH THIS FORM TO EXPEDITE SCHEDULING

SERVICE REQUEST FORM

PATIENT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

PHONE NUMBER _____ ALTERNATE NUMBER _____

EMAIL ADDRESS _____

PRIMARY DIAGNOSIS _____

DOS _____ TIME _____ INSTRUCTIONS SENT? YES NO

IS THIS A NEWBORN FOLLOW-UP? YES NO IF YES, WHICH HOSPITAL? _____

REQUESTED FOR THE FOLLOWING TEST

- AUDIOLOGICAL EVALUATION / ADULTS
 - AUDIOLOGICAL EVALUATION / PEDIATRIC
 - AURAL REHAB(HA CONSULT,ALD)
 - BAER (ABR)
 - BAER SCREEN
 - CALORICS AND POSITIONALS *** (See note below)
 - CAP TESTING
 - CRM (EPLEY)
 - ECOCHG
 - ENOG
 - EOG
 - ENG/VNG *** (See note below)
 - HEARING AID CONSULT
 - OAE
 - OFF AXIS ROTATION / SUBJECTIVE VISUAL VERTICAL
 - P300 EVOKED POTENTIAL
 - POSTUROGRAPHY (EQT/CDP) *** (See note below)
 - ROTARY CHAIR *** (See note below)
 - TILT TABLE
 - TINNITUS RETRAINING (TRT)
 - VESTIBULAR EVOKED MYOGENIC P.(VEMP)
- *** NOTE : The above test will be interpreted by a staff audiologist or Dr. T. Fife. Please select below:
- AUDIOLOGIST DR. T. FIFE NO PREFERENCE

DATE OF REFERRAL _____

REFERRING PHYSICIAN _____

CONTACT NAME _____

PHYSICIAN'S PHONE _____

PHYSICIAN'S FAX _____

PATIENT ID NUMBER _____

INSURANCE CARRIER _____

AUTH. NUMBER _____

AUTH PER _____

WORKMAN'S COMP INSURER _____

INSURANCE ADDRESS _____

AGENT NAME _____

TELEPHONE NUMBER _____

DATE OF INCIDENT _____ CLAIM _____

SPECIAL INSTRUCTIONS

PHYSICIAN SIGNATURE : _____ **DATE:** _____