dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Phone: 512-324-9999 ext. 86349 **Fax: 512-406-6521**

MARNIE PAUL SPECIALTY CARE CENTER

Please **COMPLETE** this **Physician's Order** form for pediatric audiology referrals
& have the patient's parent/guardian contact our office for an appointment.

Requesting: ☐ **Basic Audio** Children over the age of 1 ☐ **Newborn Hearing Screen** if never tested at birth ☐ **Non-sedated ABR** 0 – 3 months of age only ☐ **Sedated ABR** w/other procedure?:_____

FROM: _____

PHONE: _____ **APPT. DATE/TIME**: _____
FOR DELL CHILDREN'S OFFICE USE

FAX: _____

Full Name of Referring Physician: _____ (must be) M.D. or D.O.

Primary Care Physician: _____

Diagnosis/Reason for Referral (Check ALL that apply):

☐ Decreased hearing ☐ Otitis/inflammation of ear ☐ Speech delay
☐ Unilateral/asymmetric loss ☐ TM perforation ☐ Tinnitus
☐ Sudden hearing loss ☐ Discharge from ear ☐ Adverse affects of medication
☐ Vertigo/dizziness ☐ Ear Pain ☐ Other _____

Patient name:_____**Date of birth** __ __ / __ __ / __ __

Contact Name & Number(s): _____

Current Address: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

☐ **REQUIRES AUTHORIZATION** ☐ **DOES NOT REQUIRE AUTHORIZATION**

Auth# (please attach a copy): _____
(authorization must be obtained prior to DOS)

IMPORTANT–

YES	NO	
☐	☐	Was patient born premature? If yes, how many weeks gestation? _____
☐	☐	Have we previously tested patient?
☐	☐	Does patient have a trach tube or apnea monitor?
☐	☐	Does patient use an oxygen tank?
☐	☐	Does patient have history of cardiac or respiratory (airway) disorders? _____
☐	☐	Does patient have a Vagal Nerve Stimulator (VNS device)? (Physician's Name)
☐	☐	Does patient have any craniofacial abnormalities?
☐	☐	Does patient have Down Syndrome?

✘_____***Date:***_____***Time:*** _____

Physician Signature, Date & Time Stamp Required