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: ________________________________

FAX: ________________________________

APPT. DATE/TIME: ______________________
FOR DELL CHILDREN'S OFFICE USE

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

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

Contact Name: ____ PH#: _________________________

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? _____
☐	☐	Does patient have history of respiratory (airway) disorders? ______________________________
☐	☐	Does patient have a trach tube or apnea monitor? (Pulmonologist's Name)
☐	☐	Does patient use an oxygen tank?
☐	☐	Does patient have history of cardiac disorders? ______________________________
☐	☐	Does patient have a Vagal Nerve Stimulator (VNS device)? (Cardiologist's Name)
☐	☐	Does patient have any craniofacial abnormalities?
☐	☐	Does patient have Down Syndrome?

✘ ____ ***Date:***__________ ***Time:*** ______

Physician Signature, Date & Time Stamp Required