

t| 780.784.1349 f| 587.410.6910 www.melodyaudiology.com

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

AHC #: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Reason for Referral:

- |  |   |
|--|---|
| <input type="radio"/> Hearing test             | <input type="radio"/> Custom ear protection                   |
| <input type="radio"/> Tympanogram              | <input type="radio"/> Clean and check of current hearing aids |
| <input type="radio"/> Hearing aid consultation | <input type="radio"/> Other: _____                            |

Comments: \_\_\_\_\_

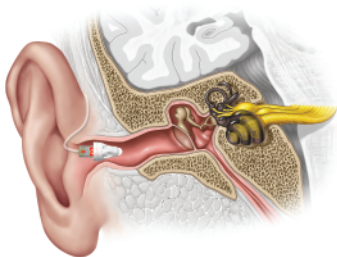
\_\_\_\_\_

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Referred by Dr. \_\_\_\_\_

Please note that our clinic only tests clients the age of 18 and older