



**AUDIOLOGY PRESCRIPTION**

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

Telephone: ( ) \_\_\_\_\_ Guardian Name (if patient is a minor): \_\_\_\_\_

Address: \_\_\_\_\_

Primary Insurance (include contract/policy #): \_\_\_\_\_

Secondary Insurance (include contract/policy #): \_\_\_\_\_

\_\_\_\_\_ Evaluate and treat - mark diagnosis listed below:

**Diagnosis list for external and middle ear concerns:**

- |                                       |                                       |
|---------------------------------------|---------------------------------------|
| _____ CHRONIC SEROUS OTITIS MEDIA     | _____ EUSTACHIAN TUBE DYSFUNCTION NEC |
| _____ ACUTE SEROUS OTITIS MEDIA       | _____ CENTRAL PERF TYMPANIC MEMBRANE  |
| _____ TYMPANOSCLEROSIS, COMBINED TYPE | _____ OTORRHEA NOS (ear drainage)     |
| _____ OTOGENIC PAIN (ear pain)        |                                       |

**Diagnosis list for types of hearing loss and speech concerns:**

- |   |  |
|---|--|
| _____ SUDDEN HEARING LOSS NOS               | _____ CONDUCTIVE HEARING LOSS, COMB TYPE |
| _____ SENSORINEURAL HEARING LOSS, COMB TYPE | _____ SUBJECTIVE TINNITUS                |
| _____ HYPERACUSIS                           | _____ SPEECH DELAY, DEVELOP ARTIC DELAY  |

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Physician Name: \_\_\_\_\_