Sound Advice
Hearing Aid Center

Date of Service _____

Patient Name _____ **Patient DOB** _____

Type of hearing loss:
☐ NORMAL ☐ SENSORINEURAL ☐ CONDUCTIVE ☐ MIXED

Degree of hearing loss:
☐ NORMAL ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND

Referring to an ENT? ☐ YES ☐ NO

Recommending prescription hearing aids? ☐ YES ☐ NO

Personalized Treatment Plan:

_____

_____

_____

_____

Your referrals are genuinely appreciated. We are currently accepting new patients and promise they will enjoy high quality healthcare in our offices, as they do in yours. Following each diagnostic visit, we will report back to you the type and degree of hearing loss as well as personalized treatment plan recommendations.

Yours In Better Hearing,

Xxxxxx Yyyy, Au.D.,
Audiologist
123 W Main St, Suite A • Anywhere IN 55555