TEXAS HEARING INSTITUTE

REFERRAL/ CONSULTATION REQUEST

FAX: 713-523-8399 ◆ PH: 713-523-3633
Referrals@texashearing.org

REFERRING PROVIDER INFORMATION

Referring Provider: _____ NPI #: _____

Facility: _____ Contact Ph: _____

Concerns/ Suspected Diagnoses (ICD codes): _____

If known, Hearing Loss Type/Severity: _____ ☐ No Known Hearing Loss Diagnosis

Additional Notes:

***Physician/PCP Signature:** _____ **Date:** _____

MEMBER INFORMATION

Patient's Name: _____ DOB: _____ ◯ Male ◯ Female

Parent/Guardian's Name(s): _____ Preferred Lang: ☐ English ☐ Spanish

Address: _____ City/ST/Zip: _____

Email(s): _____ Phone #: _____

Insurance/Medicaid: _____ ID #: _____ Grp #: _____

Insurance Plan Ph: _____ Policy Holder: _____ DOB: _____

PCP: _____ Ph: _____ Fax: _____

SERVICE PROVIDER:

Provider/Facility: **Texas Hearing Institute** (NPI: 1831239143)
Address: 3100 Shenandoah St., Houston, TX 77021

SERVICE(S) REQUESTED:

Audiology Clinic

- ☐ Behavioral Hearing Testing
- ☐ Hearing Aid Exam & Selection
- ☐ CI Mapping/Programming
- ☐ BAHA Trial & Eval
- ☐ Diagnostic ABR (Non-Sedated)
- ☐ Hearing Aid Checking/Fitting/Orientation
- ☐ Cochlear Implant (CI) Evaluation
- ☐ Other: _____

Speech Clinic

- ☐ AVT / Speech Evaluation For Therapy *(hearing loss patients)*
- ☐ AVT / Speech Evaluation For Cochlear Implant Candidacy *(hearing loss patients)*
- ☐ Speech Therapy *(no known hearing loss)*

**For Primary Care Physicians:* Please sign above to indicate approval for the requested services to this managed care patient. Be sure to include copy of their up-to-date Well Child clinicals.

*A*ll Referrals*: If available, please send the patient's audiologic testing and/or your facility's record request form signed by parent/guardian