

FIRST SOUNDS



Babies use their senses to learn about the world around them.



Over 90 percent of children in Deep East Texas are lost to follow-up after failed newborn hearing screenings



The Joint Commission on Infant Hearing states diagnostic evaluations should occur by 3 months of age



Infant diagnostic hearing evaluations are now being performed remotely in Lufkin, TX



THI-Pineywoods accepts most Medicaid plans and private insurances and offers a sliding fee scale



Referrals can be made by email or fax



Is your patient over 9 months old? We may need to provide services at our Houston location



“Chloe received an ABR and diagnosis of hearing loss at 2 months old and had access to specialized intervention. Today at 6, she is a straight A student and received an award for being her classroom’s best reader. This was possible because of an early referral from her health-care provider and the early diagnosis and intervention services she received.”



TEXAS
HEARING
INSTITUTE

FIRST SOUNDS – REMOTE ABR REFERRAL

**REFERRAL/ CONSULTATION AUTHORIZATION
REQUEST ATTENTION: BELEN RAMIREZ
FAX: 713-400-9196 PHONE: 713-337-6414
THIPineywoods@texashearing.org**



REFERRING PROVIDER INFORMATION

PCP/ENT Name: _____ PCP/ENT Office Name: _____
Address: _____
Fax #: _____ PCP Office #: _____
NPI #: _____ TAX ID: _____
Medicaid Provider #: _____ Contact Name: _____
PCP/ENT Signature: _____

MEMBER INFORMATION

Child's Name: _____ DOB: _____ MALE FEMALE
Parent/Guardian's Name(s): _____
Address: _____ City/ST/Zip: _____
Home Phone #: _____ Cell Phone #: _____
Name of Policy Holder: _____ Relationship _____ DOB: _____
INS Company: _____ Phone # _____
Insurance ID #: _____ Group #: _____ PCP: _____
PHONE: _____ FAX: _____ Medicaid _____

REFERRED TO:

TEXAS HEARING INSTITUTE – PINEY WOODS

601 ELLIS AVENUE LUFKIN, TX 75904 PHONE: 713-337-6414 FAX: 713-400-9196

REFERRED FOR:

- DIAGNOSTIC ABR (non-sedated) BAHA TRIAL & EVAL HEARING AID EXAM AND SELECTION EARMOLDS
 ABR REPORT ATTACHED **AUDIO REPORT ATTACHED**

MEDICAL RELEASE

I authorize _____ to release medical records to Texas Hearing Institute. In addition, I authorize Texas Hearing Institute and related personnel to share information deemed necessary for the effective auditory management of my child.

Signature of Parent/Guardian

Date