Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: _____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Audiology

❑ **Evaluate and treat as indicated**

Special Instructions: _____

Diagnosis: _____

ICD-CM Diagnosis Code: _____

Please check all that apply, as pre-certification / benefit check may be required.

❑ Comprehensive Audiological Evaluation (5 years-adult) Includes Pure Tone Air/Bone, SRT & word discrimination.

❑ Comprehensive Pediatric Evaluation (6 months-5 years) Includes Visual Reinforcement or Conditioned Audiometry for pure tones and speech

❑ OSHA Audiological Evaluation

❑ Otacoustic Emissions Screening/Testing

❑ Tympanometry

❑ Acoustic Reflexes/Reflex Delay

❑ Tinnitus Match

❑ Hearing Aid Assessment/Fitting

❑ Auditory Brainstem Response (ABR) (birth-5 years)

❑ Auditory Brainstem Response (ABR) (5 years - adult)

❑ Automated Auditory Brainstem Response

❑ ENG/VNG (includes Tympanometry) *(Non-compliance with pre-appointment instructions may result in cancellation of the procedure on the day of the appointment.)*

❑ Physical Therapy for Vestibular Rehabilitation if indicated by ENG/VNG results

❑ VEMP

❑ ECoG

❑ Central Auditory Processing Testing (5 years - adult) (Includes comprehensive audio, tymps, OAE, reflexes, and decay)

For Medicaid referrals, we must be provided with date of onset, diagnosis and supporting clinical notes in order to obtain authorization to treat your patient.

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #: _____

I herby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____

DeKalb Medical

FAX Orders to: 404.501.5498
Phone: 404.501.5155

PS-1054

AUDIOLOGY ORDER FORM

DMC FORM # PS-1054 (01/27/17)