**Insert logo and address**

**Hearing Referral Form**

**Audiologist**

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian of Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_, Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_:

As you know, all children participating in our program receive a hearing screening. We are pleased to offer this as a helpful resource in caring for your child’s hearing health. We have rescreened your child after follow-up with his/her primary care provider.

The results of your child’s hearing screening are as follows:

**Your Child’s Left Ear:**

**Your Child’s Right Ear:**

After reviewing your child's hearing screening results, we are recommending that a more detailed examination be scheduled with an audiologist. Our program has partnered with:

Name of Agency:

Contact information:

Types of insurance accepted:

Please make an appointment as soon as possible with this agency or another audiologist of your choice. If you have questions or concerns, please call us at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Let us know if you need any help in making this follow-up appointment.

Sincerely,

Contact names