



Hear and Say

Hear and Say –
centre for deaf children Ltd

ABN 32 058 430 069

Head Office and Brisbane Centre
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Request for Services – Referral Form

PATIENT DETAILS

Name _____

Date of birth _____

Clinical History _____

REFERRING MEDICAL PRACTITIONER DETAILS

Dr _____

Address _____

Email _____

Date of referral _____

Provider number: _____

Length of referral 1 year Indefinite

SIGNATURE _____

SERVICES REQUESTED

DIAGNOSTIC HEARING SERVICES - AUDIOLOGY

- Neonatal Hearing Assessment (under 6 months of age)
- Paediatric Hearing Assessment (under 3.5 years of age)
- Hearing Assessment (3.5 years and over)
- Electrophysiological Assessment (over 6 months of age) ABR ASSR EABR

Comments:

SPEECH THERAPY SERVICES

- Speech and Language Assessment
- Listening and Spoken Language Therapy
- Adult listening and spoken language therapy (post hearing aid and/or cochlear implant fitting)

Comments:

OCCUPATIONAL THERAPY SERVICES

- Developmental Assessment
- School Readiness Assessment

Comments:

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