ADELAIDE DIGITAL HEARING SOLUTIONS

Medical Practitioner Clearance Form

Patient information:

Title: First name: Surname:

Details of referring Medical Practitioner:

Title: First name: Surname:

Medicare Provider Number:

Address:

State: Postcode:

Telephone Number:

( )

Certification by Medical Practitioner:
I have examined this patient and (tick as appropriate)

☐ I am satisfied that there are no medical contraindictions to fitting of a hearing device.

OR

☐ I consider that there are medical contraindictions to the fitting of a hearing device.

Medical Practitioner's Signature:
(Please print referral form to sign and date below)

Date: / /

Once completed by your Medical Practitioner, simply call your local Adelaide Digital Hearing Solutions to talk about your FREE* hearing consultation today.

Call 1300 557 745 or visit digitalhearing.com.au

*FREE hearing check-up is only available to persons aged 26 years or older.