



Medical Practitioner Clearance Form

Visit digitalhearing.com.au/referral-patient-for-hearing-services/ to download this form or call your local clinic on 1300 557 745

Patient Information:

Title:

First Name:

Surname:

Details of referring Medical Practitioner:

Title:

First Name:

Surname:

Medicare Provider Number:

Address:

State: Postcode:

Telephone Number:

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Certification by Medical Practitioner:

I have examined this patient and (tick as appropriate):

I am satisfied that there are no medical contraindications to the fitting of a hearing device.

OR

I consider that there are medical contraindications 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**

*Applies to adults over 26 years only.