AudioClinic™
Hear in full colour

Medical Practitioner Clearance Form

For an electronic version of this form via email, please call your clinic on 1800 057 220.

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 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: / /

AC10125 08/13

Once completed by your Medical Practitioner, simply call your local AudioClinic to talk about your FREE* hearing consultation today.

Freecall 1800 057 220 or visit audioclinic.com.au

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