



# John Percy Audiology

The Link to Better Hearing



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**DOCTORS PLEASE NOTE:**

*\*FOR AGED or DISABILITY PENSIONERS & DEPENDANTS of PENSIONERS, VETERANS & DEFENCE FORCE PERSONNEL – Please Sign & Attach Office of Hearing Services Application.*

*\*FOR REFERRALS UNDER Enhanced Primary Care or CDM PLANS*

- USE "EPC REFERRAL FORM FOR ALLIED HEALTH PROFESSIONALS".

## REQUEST FOR CONSULTATION

To: John Percy Audiology Pty Ltd

From: Referrers Name & Provider No.

Re: Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Information (Please Tick):

**REFERRAL FOR:**

- ADULT ASSESSMENT incl. Pure Tone, Speech & Impedance Audiometry
- CHILD ASSESSMENT (6mths for VROA, 3yrs for Play Audiometry, 0mths for Otoacoustic Emission testing, 6yrs Auditory Processing)

HEARING AID or REHABILITATION REVIEW     HEARING PROTECTION

AUDITORY PROCESSING ASSESSMENTS (Children from 6yrs with LiSN-S)

EARMOULD     TINNITUS MANAGEMENT     PRE/POST EMPLOYMENT

**ENCLOSURES:**

HEALTH SUMMARY     REPORT     \_\_\_\_\_

Yours sincerely,

(Referrer's signature) \_\_\_\_\_ Date: \_\_\_\_\_