

**UNCG Speech and Hearing Center**  
**PO Box 26170, 300 Ferguson Building, Greensboro, NC 27402-6170**  
**336-334-5939 Phone, 336-334-4475 Fax**

**Referral Form**



Referred by: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Client Being Referred: \_\_\_\_\_

Gender: M F

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

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Check requested service(s):

\_\_\_\_\_ Hearing Evaluation, Adult  
(90 minutes)

\_\_\_\_\_ Hearing Evaluation, Child  
(60 minutes)

\_\_\_\_\_ Hearing Retest  
(60 minutes)

\_\_\_\_\_ Auditory Processing Disorder  
Evaluation (2 hrs)

\_\_\_\_\_ Tinnitus Evaluation  
and Tinnitus Retraining Therapy (3 hrs)

\_\_\_\_\_ Hearing Aid Consultation

\_\_\_\_\_ Individual Aural Rehab Therapy

\_\_\_\_\_ Group Aural Rehab Therapy

\_\_\_\_\_ Speech- Language Evaluation  
(2 ½ -3 hrs)

\_\_\_\_\_ Speech-Language Therapy

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

\_\_\_\_\_

\_\_\_\_\_

Client's Insurance Co.: \_\_\_\_\_ Medicaid # for under 21yrs old only:\*

*\*Remind client to bring written Primary Care Physician's referral*

**\*\*\*We are not currently a Medicare provider. Patient will not be reimbursed for visit.\*\*\***

**Note:** Once this form is returned, we will send the client a history questionnaire to complete and return to begin the appointment process.

**Name of contact, person or agency referring client, and telephone number:**

\_\_\_\_\_

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