HEARING THERAPY SERVICES

THIS IS A FREE SERVICE TO NZ CITIZENS / PERMANENT RESIDENTS
Please refer persons less than 16 years of age to Hearing/Vision Tester, Community Health Services

Mr / Mrs / Miss Other	Surname	First Names

Address ________________ ________________ ________________ Currently using hearing aids **Y** **N** Previously worn hearing aids **Y** **N**	Phone No. ________ D.O.B ___/___/___ NHI No: ________ War Pension No: ________ ACC No: ________
☐ Hearing Evaluation	☐ Tinnitus Information & Help
☐ Hearing Aid Information	☐ Hearing Aid Management
☐ Assistive Devices Information (phones, TV etc) – advice, demonstration, trial, management	
☐ Meniere's Information & Help	☐ Communication / Hearing Loss Coping Strategies
☐ Guidance for Families & Patient	
Referred By: Date of referral:	Doctor's Details:
Copy of report to:	
AN APPOINTMENT IS NECESSARY - PLEASE PHONE: *(Individual clinic details are inserted and this statement removed)* ___/___/___ appointment Date	________________ appointment time