SOUND RELIEF
TINNITUS & HEARING CENTER

Physician Referral Form

soundrelief.com

SEND THIS COMPLETED FORM, WITH THE PATIENT'S PERTINENT RECORDS AND INSURANCE CARD, TO THE CLINIC CHECKED BELOW UNDER "PREFERRED LOCATION."

REFERRING PROVIDER

PROVIDER NAME _____ NPI _____ DATE (MM/DD/YYYY) _____

PRACTICE / CLINIC NAME _____

PHONE _____ FAX FOR RETURN CORRESPONDENCE _____ SECURE EMAIL _____

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH (MM/DD/YYYY) _____ SEX _____

PATIENT PHONE _____ BEST TIME / WAY TO CONTACT _____ PATIENT EMAIL _____

INSURANCE CARRIER _____ MEMBER ID _____ GROUP # _____

PREFERRED SOUND RELIEF LOCATION (CHECK ONE)

COLORADO

☐ **Boulder**
Phone (303) 225-4534
Fax (720) 964-0602
srhc_boulder@soundrelief.com

☐ **Denver**
Phone (303) 856-3627
Fax (303) 223-9371
srhc_denver@soundrelief.com

☐ **Fort Collins**
Phone (970) 682-2779
Fax (970) 797-1134
srhc_fortcollins@soundrelief.com

☐ **Golden**
Phone (720) 726-5838
Fax (303) 379-5894
srhc_golden@soundrelief.com

☐ **Highlands Ranch**
Phone (720) 344-7600
Fax (303) 346-5036
srhc_highlandsranch@soundrelief.com

☐ **Westminster**
Phone (720) 486-0171
Fax (303) 379-5926
srhc_westminster@soundrelief.com

ARIZONA

☐ **Mesa**
Phone (480) 590-6940
Fax (480) 530-9413
srhc_mesa@soundrelief.com

☐ **Peoria**
Phone (623) 208-4086
Fax (928) 272-7010
srhc_peoria@soundrelief.com

☐ **Scottsdale**
Phone (480) 588-3180
Fax (480) 656-6211
srhc_scottsdale@soundrelief.com

REASON FOR REFERRAL (CHECK ALL THAT APPLY)

- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Sound hypersensitivity (hyperacusis or Misophonia)
- ☐ Cerumen (Ear Wax) Management
- ☐ Tympanometry (Check Ear Drum Function)

OTHER REASON / CLINICAL QUESTION

RECORDS ATTACHED (CHECK ALL THAT APPLY)

- ☐ Prior audiogram
- ☐ ENT / clinic notes
- ☐ Imaging report (MRI / CT)
- ☐ Medication list
- ☐ Insurance card
- ☐ Other (note below)

PERTINENT HISTORY & CLINICAL NOTES

Onset, prior workup, ototoxic exposures, current medications, etc.

URGENCY

- ○ Routine
- ○ Priority (within 1-2 weeks)
- ○ Urgent (call to coordinate)

PREFERRED RESPONSE METHOD (WHERE TO SEND THE REPORT)

- ○ Fax to provider
- ○ Secure email
- ○ Mail
- ○ EHR / Direct messaging

REFERRING PROVIDER SIGNATURE

DATE (MM/DD/YYYY)