WESTERN HEARING SERVICES
& TINNITUS MANAGEMENT

Medical Practitioner Clearance Form

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 contraindictions to fitting of a hearing device.

OR

☐ I consider that there are medical contraindictions to the fitting of a hearing device.

Medical Practitioner's Signature:
(Please print referral form to sign and date below)

Date: / /

Once completed by your Medical Practitioner, simply call your local Western Hearing Services to talk about your consultation today.

Freecall 1800 622 121 or visit westernhearing.com.au