Patient Information (Required for Scheduling)

Patient Name: ______________________ DOB: ____________ Sex: ❑ M ❑ F SS#: ____________
First & Last Name

Patient's Address: ______________________ ______________________ ____________ ____________
Street City State Zip Code

Home Phone#: ____________ Mobile Phone #: ____________ Email Address: ____________

Primary Insurance: ______________________ Policy #: ____________ Group #: ________ Phone #: ____________
Plan & Product

Secondary Insurance: ______________________ Policy #: ____________ Group #: ________ Phone #: ____________
Plan & Product

Order Information - Audiology

❑ **Evaluate and treat as indicated**

Special Instructions: ____

Diagnosis: ____

ICD-CM Diagnosis Code: ____

Please check all that apply, as pre-certification / benefit check may be required.

- ❑ Comprehensive Audiological Evaluation (5 years-adult) Includes Pure Tone Air/Bone, SRT & word discrimination.
- ❑ Comprehensive Pediatric Evaluation (6 months-5 years) Includes Visual Reinforcement or Conditioned Audiometry for pure tones and speech
- ❑ OSHA Audiological Evaluation
- ❑ Otacoustic Emissions Screening/Testing
- ❑ Tympanometry
- ❑ Acoustic Reflexes/Reflex Delay
- ❑ Tinnitus Match
- ❑ Hearing Aid Assessment/Fitting
- ❑ Auditory Brainstem Response (ABR) (birth-5 years)
- ❑ Auditory Brainstem Response (ABR) (5 years - adult)
- ❑ Automated Auditory Brainstem Response
- ❑ ENG/VNG (includes Tympanometry) *(Non-compliance with pre-appointment instructions may result in cancellation of the procedure on the day of the appointment.)*
- ❑ Physical Therapy for Vestibular Rehabilitation if indicated by ENG/VNG results
- ❑ VEMP
- ❑ ECoG
- ❑ Central Auditory Processing Testing (5 years - adult) (Includes comprehensive audio, tymps, OAE, reflexes, and decay)

For Medicaid referrals, we must be provided with date of onset, diagnosis and supporting clinical notes in order to obtain authorization to treat your patient.

Referring Physician Information

Physician Name (first & last): ______________________ NPI#: ____________ GA License#: ____________

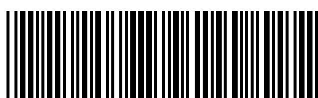
Physician Address: ______________________ Phone#: ____________ Fax #: ____________

I herby certify that the services indicated in the above order form are medically necessary.

Physician Signature: ______________________ Date: ________ Time: ________

DeKalb Medical

FAX Orders to: 404.501.5498
Phone: 404.501.5155



PS-1054

AUDIOLOGY ORDER FORM

DMC FORM # PS-1054 (01/27/17)