



## HEARING CONSERVATION DIAGNOSTIC/CENTER REFERRAL

1. TO: (BASE AND LOCATION, INCLUDE ZIP CODE)				2. FROM: (BASE AND LOCATION, INCLUDE ZIP CODE)									
				PAS CODE									
3. NAME OF REFERRING OFFICER				4. PHONE NUMBER				5. DATE (Year, Month, Day)					
6. REASONS FOR REFERRAL (TO BE COMPLETED BY REFERRING OFFICER)													
A. COMPLAINT OF NOT BEING ABLE TO HEAR OR UNDERSTAND AND ROUTING SPOKEN COMMUNICATION, AUDITORY CUES OR SIGNALS				D. SHOWS PERMANENT THRESHOLD SHIFT ON 40 HOUR NFA									
B. HAS DIFFICULTY WEARING STANDARD HEARING PROTECTION DEVICES OR COMMUNICATION EQUIPMENT				E. DFU-TS ON DETAILED FOLLOW-UP HEARING TEST									
C. INVALID OR UNRELIABLE TEST RESULTS SUGGESTING AN EXAGGERATED HEARING LOSS, OR A NON-ORGANIC ILLNESS OR DISEASE				F. OTHER (See Remarks)									
7. REMARKS													
8. RECOMMENDATIONS/DISPOSITIONS/RESULTS (TO BE COMPLETED BY AUDIOLOGIST AND ENT PHYSICIAN)													
A. RETURN TO <i>UNRESTRICTED</i> DUTY AND CONTINUE FOLLOW-UP				D. REESTABLISH REFERENCE AUDIOGRAM									
B. RETURN TO DUTY WITH RESTRICTION OR ACCOMMODATION (See Remarks)				E. RE-FIT AND AND ISSUE HEARING PROTECTION DEVICES									
C. DISCONTINUE FURTHER EXPOSURE TO HAZARDOUS NOISE				F. OTHER (See Remarks)									
9. REMARKS													
10. MEDICAL RECORDS AVAILABLE AT THE TIME OF EXAM?										YES		NO	
11. PAS CODE NUMBER													
12. AUDIOLOGIST'S SIGNATURE						13. PHONE NUMBER			14. DATE OF EVAL (Year, Month, Day)				
15. ENT PHYSICIAN'S SIGNATURE						16. PHONE NUMBER			17. DATE OF EVAL (Year,Month, Day)				
						18. PATIENT'S NAME (Last, First, Middle Initial)							
						19. SSN			20. PAY GRADE		21. DATE OF BIRTH (Year, Month, Day)		
						22. STATUS <input type="checkbox"/> 1. ACTIVE 2. RESERVE 3. NATIONAL GUARD 4. CIVILIAN 5. OTHER							
						23. WORK PLACE IDENTIFIER						24. AFSC/CSDC	