

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 | |