THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

AUDIOLOGY AND
SPEECH PATHOLOGY

Audiology and Speech Pathology Clinic at
UT Conference Center
600 Henley Street, Suite 213
Knoxville, Tennessee 37996
Phone: 865-974-5453 (voice, VRS)
Fax: 865-974-1792

Form revised 11/2024

REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____DOB: _____ Preferred Language: _____

Parent/Spouse/Guardian: _____ Gender: [ ] Male [ ] Female [ ] Non-binary [ ] Other _____

Address: _____City: _____State: _____Zip: _____

Primary Phone: _____ Secondary Phone: _____ Email _____

PERTINENT MEDICAL HISTORY with ASSOCIATED ICD-10 DIAGNOSIS CODE/S_____

_____

HEARING-BALANCE-TINNITUS-AURAL REHABILITATION SERVICES: (*Check all appropriate*)

MEDICAL CLEARANCE: Is there any medical basis to contraindicate the use of hearing aids if the patient meets candidacy? Yes _____ No _____

[ ] Adult Hearing Evaluation [ ] Ototoxicity Audiologic Monitoring

[ ] Cerumen Management

[ ] Pediatric Hearing Evaluation (incl. speech-language and/or vestibular evaluation and/or auditory brainstem response (ABR) evaluation, if indicated)

[ ] Amplification Evaluation (incl. speech-language and/or vestibular evaluation, if indicated)

[ ] Auditory Processing Evaluation - Age 7 and older with typical cognitive functioning (incl. speech-language evaluation, if indicated)

[ ] Vestibular Evaluation and Treatment, if needed (New evaluations consist of 1-3 visits)

[ ] Tinnitus Evaluation (incl. a hearing evaluation, if indicated) Tinnitus is: [ ] constant [ ] intermittent. Symptoms of: [ ] Misophonia [ ] Hyperacusis

[ ] ABR Evaluation: [ ] threshold estimation or [ ] neurological/differential diagnosis (with hearing evaluation, if needed)

[ ] Cochlear Implant Programming

[ ] Cochlear Implant Assessment (Pre/Post) with vestibular evaluation Date of CI surgery**:** _____

[ ] Aural Re/Habilitation: Evaluate and Treat

SPEECH-LANGUAGE-VOICE-FEEDING-SWALLOWING SERVICES (*Check all appropriate*)

[ ] Evaluate (incl. hearing evaluation, if indicated)
[ ] Treat

AREA(S) OF CONCERN:

[ ] Speech [ ] AAC [ ] Traumatic Brain Injury [ ] Stuttering [ ] Apraxia [ ] Autism [ ] ALS [ ] Literacy
[ ] Language [ ] Voice [ ] Feeding/Swallowing [ ] Aphasia [ ] Cognition [ ] Parkinson's [ ] Hearing

ADDITIONAL PROCEDURES: [ ] Stroboscopy (Voice) [ ] Fiberoptic Endoscopic Evaluation of Swallowing (FEES) [ ] Lymphatic Therapy
[ ] Voice Prosthesis: Evaluate and/or Fit

PROVIDER INFORMATION

Referring Physician: _____

Address: _____

Phone #: _____Fax #: _____

Provider's NPI:_____

Primary Care Provider: _____

Phone #: _____Fax #: _____

Provider's NPI: _____

INSURANCE INFORMATION (Please send copy of card – front and back)

Insurance Carrier: _____

Medicare? Yes/No Supplemental? Yes/No TennCare? Yes/No

Subscriber ID#: _____ Group #: _____

Is a **pre-cert or authorization number Required**? Yes or No

Authorization/pre-cert #: _____# of visits: _____

PLEASE NOTE This referral is effective for established patients one year from the date received. Our clinic will send requests to update referrals on established patients.

Referring Provider's Signature: _____ **Date:** _____