REFERRAL FORM FOR AUDIOLOGY SERVICES
SCHOOL-BASED SETTING

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School District or Education Service Cooperative Receiving Referral

I have performed a clinical assessment of the patient named below, for whom I am referring:

______________________________ Audiology Services ____

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Duration (check one): ☒ **school year** (20____-20____) ☐ other: ___________________________

Please advise me, as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide subsequent to this referral. Please note that services beyond the scope of this referral require a new referral. Referrals for ongoing services require renewal each time a new IEP is written.

______________________________	______________________________
Medicaid Beneficiary Name	Medicaid I.D. Number
______________________________	______________________________
PCP/Attending Physician Name (Please print, stamp or type physician's name)	PCP/Attending Physician NPI/Taxonomy
______________________________	______________________________
PCP/Attending Physician Signature	PCP/Attending Physician Phone Number

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Date

Please return this form to your PCP and keep a copy in the file