Time 2 Hear – Referral Form

Auditory Processing • Tinnitus Management • Hearing Assessment • Wax Removal

1. Referrer Details

Name: _____
Profession / Role: _____
Organisation: _____
Phone: _____
Email: _____

2. Client Details

Name: _____
DOB: ____ / ____ / ____
Phone: _____
Email: _____
Address: _____

3. Reason for Referral *(tick all that apply)*

☐ Auditory Processing Difficulties (APD)
☐ Tinnitus (ringing / buzzing / noise in ears)
☐ Hearing concerns / communication difficulties
☐ Earwax blockage
☐ Other: _____

4. Presenting Concerns / Symptoms

(Please provide brief details)

_____

_____

_____

7. Consent to Share Information

I confirm that the client/parent has consented to this referral and information sharing between Time 2 Hear and the referrer.

Signature: _____
Date: ____ / ____ / ____

8. Additional Notes / Recommendations

_____

_____

_____

9. Send Referral

Email: hello@time2hear.com.au 07) 3059 9866 www.time2hear.com.au