MEDICAL CLEARANCE

FOR

HEARING AID CANDIDACY

DATE: ______________________

PATIENT'S NAME: _______________________________________

ICD-10:______________________

The above patient has been medically evaluated and may be considered a candidate for a hearing aid.

PHYSICIAN'S SIGNATURE: ________________________________

PHYSICIAN'S NAME (PRINTED): ___________________________

PHYSICIAN'S NPI:____

PLEASE RETURN THIS FORM TO:

Pacific Audiology Clinic
3502 NE Broadway
Portland, OR 97232
FAX: 503-546-0894