Lancaster Cleft Palate Clinic

Helping children and adults achieve a bright and happy future since 1938.

Date of Referral_____

Patient Name_____Patient Date of Birth_____

Address_____City_____State_____Zip_____

Phone_____Work/Cell_____

Reason for Referral

- Hearing Screening
- Audiological Evaluation (w/ Diagnostic Report)
- Sound field Aided Testing
- Hearing Aid Check/Hearing Technology Evaluation
- Custom Ear plugs/mold Swim____Musician_____Noise_____
- Newborn Hearing Outpatient Screening
- Diagnostic Auditory Brainstem Response Testing
- Distortion Product Otoacoustic Emissions
- Immittance/Tympanometry Testing
- Auditory Processing Evaluation

Medical Clearance for Amplification _____

(Physician Signature)

Referring Physician_____NPI_____

Physician Phone_____Fax_____

Physician Signature_____Date_____