Communication Matters
Jacksonville
Speech & Hearing Center

1128 N. Laura St
Jacksonville, FL 32206
Phone: (904) 355-3403
Fax: (904) 355-4149

REFERRAL FORM
JACKSONVILLE SPEECH AND HEARING CENTER

*Referring Office/Physician Name: _____

*Referring Office Address: _____

*Referring Office Phone: _____ *Referring Office Fax: _____

*Required information. Please print clearly.

****PLEASE INCLUDE ALL PATIENT DEMOGRAPHICS & INSURANCE INFORMATION****

Patient Name: _____ **D.O.B:** _____

Guardian/Parents Name: _____

Patient Address: _____

City/State: _____ **Zip:** _____

Phone#: _____ **Alternate#:** _____

Insurance Company: _____

Policy/ID #: _____ **Group#:** _____ **Insurance Tel#:** _____

Reason for Referral: (Please check all boxes that apply)

- ☐ Hearing Evaluation
- ☐ Amplification
- ☐ Tinnitus Assessment
- ☐ Auditory Processing Disorder Evaluation (APD) Age 8-18
- ☐ Speech/language Evaluation
  *****Hearing Evaluation required for children under 4*****
- ☐ Speech/language Therapy

Brief description of problem: _____

Referring Physician's Signature: _____ *NPI#: _____

Print Physician Name: _____ Date: _____

Please fax this completed form to our office at 904.355.4149. Our office will contact the patient to schedule the appointment. If you have any questions, please call 904.355.3403. Thank you very much.

Visit us online at: www.shcjax.org