HEARING CONSERVATION DIAGNOSTIC/CENTER REFERRAL

1. **TO:** *(BASE AND LOCATION. INCLUDE ZIP CODE)*	2. **FROM:** *(BASE AND LOCATION, INCLUDE ZIP CODE)*
	PAS CODE

3. NAME OF REFERRING OFFICER	4. PHONE NUMBER	5. DATE *(Year, Month, Day)*

6. REASONS FOR REFERRAL (TO BE COMPLETED BY REFERRING OFFICER)

	A. COMPLAINT OF NOT BEING ABLE TO HEAR OR UNDERSTAND AND ROUTING SPOKEN COMMUNICATION, AUDITORY CUES OR SIGNALS		D. SHOWS PERMANENT THRESHOLD SHIFT ON 40 HOUR NFA
	B. HAS DIFFICULTY WEARING STANDARD HEARING PROTECTION DEVICES OR COMMUNICATION EQUIPMENT		E. DFU-TS ON DETAILED FOLLOW-UP HEARING TEST
	C. INVALID OR UNRELIABLE TEST RESULTS SUGGESTING AN EXAGGERATED HEARING LOSS, OR A NON-ORGANIC ILLNESS OR DISEASE		F. OTHER *(See Remarks)*

7. REMARKS

8. RECOMMENDATIONS/DISPOSITIONS/RESULTS (TO BE COMPLETED BY AUDIOLOGIST AND ENT PHYSICIAN)

	A. RETURN TO *UNRESTRICTED* DUTY AND CONTINUE FOLLOW-UP		D. REESTABLISH REFERENCE AUDIOGRAM
	B. RETURN TO DUTY WITH RESTRICTION OR ACCOMMODATION *(See Remarks)*		E. RE-FIT AND AND ISSUE HEARING PROTECTION DEVICES
	C. DISCONTINUE FURTHER EXPOSURE TO HAZARDOUS NOISE		F. OTHER *(See Remarks)*

9. REMARKS

10. MEDICAL RECORDS AVAILABLE AT THE TIME OF EXAM?		YES		NO
11. PAS CODE NUMBER				

12. AUDIOLOGIST'S SIGNATURE	13. PHONE NUMBER	14. DATE OF EVAL (Year, Month, Day)
15. ENT PHYSICIAN'S SIGNATURE	16. PHONE NUMBER	17. DATE OF EVAL (Year,Month, Day)

	18. PATIENT'S NAME (Last, *First, Middle Initial)*		
	19. SSN	20. PAY GRADE	21. DATE OF BIRTH *(Year, Month, Day)*
	22. STATUS ☐ 1. ACTIVE 2. RESERVE 3. NATIONAL GUARD 4. CIVILIAN 5. OTHER		
	23. WORK PLACE IDENTIFIER		24. AFSC/CSDC