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For appointment  
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Email: AMK\_Specialist\_Centre@ttsh.com.sg

**COMMUNITY AUDIOLOGY**

**TTSH ANG MO KIO SPECIALIST CENTRE (AMKSC)  
REFERRAL FORM**

\*Please select one or both options

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PART I: PATIENT PARTICULARS** | | | | |
| Name |  | | Male / Female | |
| NRIC No. |  | | Contact No. |  |
| **PART II: DOCTOR’S REFERRAL** | | | | |
| Referral Type | Subsidised referral if applicable  Private referral | | | |
| Diagnosis / Comments |  | | | |
| Ordered Test | Hearing Diagnostic Package (Otoscopy image, Audiogram, Tympanogram and Audiologist Report)  Audiogram  Tympanogram  Acoustic Reflex Test  Hearing Aid Evaluation and Fitting (if suitable after Audiogram) | | | |
| Audiology Report | Patient to collect  Email to referring doctor | | | |
| **PART III: DOCTOR’S INSTRUCTION\*** | | | | |
| Patient to be referred back to my clinic.  Patient to continue hearing rehabilitation care by AMKSC Audiology, or TTSH ENT SOC (if required).  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name & Signature of Practitioner MCR No. Date | | | | |
| Clinic Name |  | Clinic HCI Code | |  |
| Clinic Address |  | | | |
| Clinic Email |  | Clinic Contact No. | |  |

Please remind patients to bring this referral form with their NRIC for verification on the day of their appointment.

For enquiries on audiology services, please email audiology\_amksc@ttsh.com.sg