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For appointment
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**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