

**Vanderbilt Bill Wilkerson Center**

**Provider Order Form: Adult Audiology**

Patient's Name:	MRN:	DOB:	Age (yrs):
Parent(s)/Guardian(s) Name(s)	Spoken Language At Home:		
Patient's Address:			
Patient/Family Contact (Home):	Cell:	Work:	
Primary Insurance Company:	ID #:	Contact #:	
Secondary Insurance Company:	ID #:	Contact #:	

Electronic orders are another option through **Vanderbilt Health Connect (VHC)**. VHC allows for record review and electronic order request. Register now at <https://vanderbilthealth.com/main/54271>.

If the patient is experiencing ear pain, pressure, or drainage, OR there is concern for falling, consider an **Ambulatory Referral to Otolaryngology (Ear, Nose, Throat & Voice)** and fax to 615-936-8929 or call 615-322-6180 for scheduling.

**SERVICES REQUESTED:**

- ☐ **Comprehensive Hearing Evaluation** - Routine test battery based on age/developmental abilities  
 What is the primary concern?:  
     ☐ Hearing loss  
     ☐ Tinnitus  
     ☐ Hearing Aid Adjustment  
 Does the patient wear hearing aids?  
     ☐ Yes  
     ☐ No
- ☐ **Hearing Aid Selection** - Scheduled on same day as Comprehensive Hearing Evaluation
- ☐ **Bone Anchored Implant Evaluation** – Need a hearing evaluation within 1 year. If needed, also order Comprehensive Hearing Evaluation
- ☐ **Tinnitus Evaluation** – tinnitus which has impact on concentration, sleep, quality of life. Includes hearing evaluation and consult on the management of bothersome tinnitus
- ☐ **Vestibular Function Test (VFT)** – Comprehensive test battery includes: Videonystagmography (VNG), Sinusoidal Harmonic Acceleration (SHA), Video Head Impulse Test (vHIT), and Vestibular Evoked Myogenic Potentials (VEMPs)
- ☐ **Integrated Falls Risk Assessment:** VFT with Audiology, plus Postural & Gait Assessments with Physical Therapy

**Cochlear Implant (CI) Candidacy Evaluation** – Do not use this form. Instead, fax patient demographics, a copy of insurance card, as well as the most recent hearing test to our CI Coordinator: **Phone: 615-875-1038 FAX: 615-936-7374**.

- |  |  |
|--|--|
| <input type="radio"/> H90.0 Conductive Hearing Loss, bilateral<br><input type="radio"/> H90.2 Conductive Hearing Loss, unspecified<br><input type="radio"/> H90.3 Sensorineural Hearing Loss, bilateral<br><input type="radio"/> H90.5 Sensorineural Hearing Loss, unspecified<br><input type="radio"/> H90.6 Mixed Hearing Loss, bilateral<br><input type="radio"/> H90.8 Mixed Hearing Loss, unspecified<br><input type="radio"/> R26.81 Unsteadiness on Feet<br><input type="radio"/> R29.6 Repeated Falls<br><input type="radio"/> Z91.81 History of Falling<br><input type="radio"/> Other: _____ | <input type="radio"/> H81.10 Benign Paroxysmal Positional Vertigo (BPPV), Unspecified Ear<br><input type="radio"/> H81.11 Benign Paroxysmal Positional Vertigo (BPPV), Right Ear<br><input type="radio"/> H81.12 Benign Paroxysmal Positional Vertigo (BPPV), Left Ear<br><input type="radio"/> H81.13 Benign Paroxysmal Positional Vertigo (BPPV), Bilateral<br><input type="radio"/> H81.391 Peripheral Vertigo, Right Ear<br><input type="radio"/> H81.392 Peripheral Vertigo, Left Ear<br><input type="radio"/> H81.393 Peripheral Vertigo, Bilateral<br><input type="radio"/> H81.399 Peripheral Vertigo, Unspecified Ear<br><input type="radio"/> H81.4 Vertigo of Central Origin<br><input type="radio"/> R42 Dizziness and Giddiness |
|--|--|

Provider's Signature:	Date:		
Provider's Name (print):	<table style="width: 100%;"> <tr> <td style="width: 40%;">Phone Number:</td> <td style="width: 60%;">Fax Number:</td> </tr> </table>	Phone Number:	Fax Number:
Phone Number:	Fax Number:		

**Fax this completed form to 615-936-5088**