

INTAKE/REFERRAL FORM
REVISED



3525 NW 56th Street
Suite A-150
Oklahoma City, OK 73112
Phone: 405.548.4300
Fax: 405.548.4350

Today's Date: _____

Referred by _____

Patient LAST Name:		Date of Birth:
Patient FIRST Name:		Sex: Male or Female
Full Name of Legal Caregiver/Parents:		SS#
Address:		
City/State/Zip:		
Cell Phone:	Home:	Work:
Email Address (please print):		
Newborn Hearing Screening Results (if Child): ___ Pass or ___ Referred - Hospital Where NBHS Performed:		

REFERRAL INFORMATION, IF SOONER START CHILD – AGES 0-3 YEARS:

SS County _____	SS FAX #: _____
SS Resource Coordinator's Name, Phone & EXT #: _____	
SS Provider's Name, Phone & EXT #: _____	
SS Billing Address for Child's Services: _____	
Supporting Documentation: _____	Previous Audiometric Testing Results _____ IFSP _____ Other _____
	_____ Eligibility Determination

REFERRAL INFORMATION FOR ALL OTHER PATIENTS:

Ref Ofc Phone: _____	Ref Ofc FAX: _____	Ref Ofc Contact Name: _____
Ref Contact Email Address: _____		
Primary Care MD's Name, Address & Phone: _____		
Insured's Name: _____	Insured's SS#: _____	
Insurance Company: _____	Ins Co Phone #: _____	
Insured's ID# _____	Group or Plan #: _____	
Authorization Attached: _____ Yes or _____ No	Is Authorization Required: _____ Yes _____ No	

Presenting Concerns: _____

HfH USE ONLY

HfH Appt Date:

Time: _____ with _____