



Columbia Regional Program

Audiology Services
833 NE 74th Ave
Portland, OR 97213

Phone: (503) 916-5570

Fax: (503)916-5576

Otologic Statement

Name of Patient: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Parents: _____ Referring Audiologist: _____

To Be Completed By Physician:

1. Is the hearing loss sensorineural?
Right Ear: Yes No
Left Ear: Yes No
2. If the hearing loss is conductive, is it currently untreatable by a physician?
Right Ear: Yes No
Left Ear: Yes No
3. Is the condition of this child's ear such that she/he could wear an earmold?
Right Ear: Yes No
Left Ear: Yes No
4. Medical clearance is given to wear amplification:
Right Ear: Yes No
Left Ear: Yes No

Physician's OMAP provider number: _____

(Federal law requires an
M.D. or D.O. Signature.)

(Physician's Signature)

(Date)

Physician's Name (Please Print) _____

Address: _____ Zip: _____

Phone: _____ Fax: _____

Please return completed form to Audiology Services at the above address.