

Referral To: **humboldt audiology**

831 Harris Street, Suite D  
Eureka, CA 95503  
443-7111 phone • 443-7117 fax  
www.humboldtaudiology.com

Joanna Marcuz, Au.D.  
DOCTOR OF AUDIOLOGY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent's name (if patient is a minor): \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Purpose of Referral:

- Diagnostic Audiological Evaluation (Adult)  
I am referring this patient for an audiological evaluation to assist with diagnosis and management.
- Pediatric Diagnostic Audiological Evaluation
- Pediatric Follow-up Appointment (Audio re-test)
- Hearing Aid Evaluation and Consultation
- Other \_\_\_\_\_

Notes:

Referred By: \_\_\_\_\_ NPI# \_\_\_\_\_  
Please Print Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_

**NOTE:** Please attach any relevant chart notes, and copies of insurance cards.  
*Thank you for your kind referral.*