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DOCTOR HEARING RESULTS

Please check your results and return to:

First Step ICF

Phone:

Fax:

Child's Name: _____

Date of Birth: _____

- 1. _____ Ears were clear-no treatment necessary at this time.
- 2. _____ Removed cerumen
- 3. _____ Prescribed medication for middle ear fluid or ear infection.
- 4. _____ Referred to ENT for further evaluation .Doctor refferd to:
- 5. _____ Please send a copy of the hearing test if testing is completed at your office.
- 6. _____ This is a demo entry.

COMMENTS: _____

Physician's Signature

Physician's Signature

Date