ARAFURA Audiology
EAR & HEARING CLINIC
101 Mitchell Street Darwin NT 0800 Tel (08) 8981 0013 Fax (08) 8981 0275
Tropical Ear Pty Ltd
ABN 59 084 168 383

REFERRAL FOR: Auditory Processing Assessment

Referral Source: _____

_____

_____

Patient Details

Surname: _____ First Name: _____

Age: _____ DOB: _____

(must be more than 7 years of age)

Primary Language: _____

Known Conditions:

☐ ADHD ☐ AUTISM ☐ S & L DELAY

☐ SYNDROME – Please specify _____

Presenting Symptoms:

_____

_____

_____

_____

_____

_____

NOTE:
Please provide any relevant prior speech/psychology/medical reports