Logo

Description automatically generatedREFERRAL TO **COCHLEAR IMPLANT PROGRAM** AT VANDERBILT UNIVERSITY MEDICAL CENTER

*Thank you for your referral!*

**Referring Clinic/Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring for:**

* New Patient – cochlear implant candidacy assessment
* Existing Patient – needs audiology and/or ENT follow-up
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please fax or email the following records as soon as possible:

* Patient demographics including support person’s name and number if patient needs help with scheduling appointments
* Copy of insurance card (front and back)
* Most recent audiogram (audiogram < 1 year old is required)
* If patient has had an MRI and/or CT, please prepare them to hand carry disks to ENT consult appointment or upload at https://vumc.ambrahealth.com/share/ent\_vumc.
* If you are referring a patient who already has a cochlear implant, please email their most recent programming file to cochlearimplant@vumc.org.

Cochlear Implant Coordinator

**Phone Number:** (615) 875-1038

**Fax:** (615) 936-7374

**E-mail:** cochlearimplant@vumc.org

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