Referral Form - Audiology Services

Fax # 613-526-7126

Client's personal information

Given name	Last name	Date of birth (dd/mm/yyyy)	Age	Gender ☐ M ☐ F ☐ Other
Address (Unit, Street#, Street Name) City Province Postal Code				Preferred Pronouns
Home telephone #	☐ Work or ☐ cell telephone #	Languages spoken by the client: ☐ English ☐ French ☐ Other (specify)		

Insurance coverage ☐ DVA/VAC K# _____ ☐ WSIB _____ ☐ ODSP _____

☐ OHIP _____ ☐ Private Insurance (please specify) _____

Substitute-decision maker **Please note, OHIP does not cover the cost of hearing assessments/wax removal

Given name	Last name	Relationship to client
Telephone # to book appointments		Preferred language ☐ English ☐ French

Reasons for referral (Select all that apply)

- ☐ Infant Screening (0-6mo)
- ☐ Peripheral Hearing Assesment (rule out hearing loss 6mo+)
- ☐ APD - Auditory Processing Disorder Assessment (7 years+)
- ☐ Parental concerns regarding hearing difficulty
- ☐ Suspected Hearing Loss (not related to middle ear fluid/infection
- ☐ Hearing reassessment
- ☐ Middle Ear problems - history of recurrent otitis media
- ☐ Speech and Language Concerns
- ☐ Sudden Onset hearing loss **(last 24-48 hours)**
- ☐ Tinnitus
- ☐ Hearing Aid Evaluation
- ☐ Earwax/Cerumen Removal
- ☐ School Concerns
- ☐ Other (please specify)

Does the client wear hearing aids? ☐ No ☐ Yes Year purchased

Is your referral related to a specific diagnosis or any specific observations? ☐ No ☐ Yes (specify)

Source of referral (How did you hear about the clinic?)

☐ Word of Mouth	☐ Online Search	☐ CHEO	☐ School	☐ ENT
☐ Family doctor	☐ Self-refer	☐ Other (specify)		

Family Doctor	**Referring Healthcare Provider**
First & Last Name	First & Last Name
Address	Address
Telephone #	Telephone #