REFERRAL FOR HEARING SERVICES

LAST NAME FIRST NAME		☐ MALE ☐ FEMALE ☐ IDENTIFIES AS:	DATE OF REFERRAL
ADDRESS (Including postal code) **EMAIL ADDRESS:**			PHONE NUMBER **PRIMARY#:** **SECONDARY#**
DATE OF BIRTH	PHYSICIAN Please include initial		CARE CARD NUMBER
PARENT/GUARDIAN NAME			HAS PARENT/GUARDIAN BEEN NOTIFIED ☐ YES ☐ NO
NAME OF SCHOOL/PRESCHOOL			GRADE

REFERRED FOR:

☐ AUDIOLOGICAL EVALUATION ☐ HEARING AID CONSULTATION ☐ SWIMMOLDS/CUSTOM EARMOLDS

REASON FOR REFERRAL/PERTINENT MEDICAL HISTORY AND COMMENTS:

Rule-out hearing loss:

- ☐ Speech/language delay
- ☐ Parental concern
- ☐ School or academic concerns
- ☐ General check
- ☐ Sensitive to loud sounds

Regular request for audiology assessment:

- ☐ Ear infections/middle ear fluid
- ☐ Pre/post surgery audiogram
- ☐ Suspected/known hearing loss
- ☐ Issuance of hearing aids as required
- ☐ Risk factor for hearing loss:

Urgent request for audiology assessment:

- ☐ Sudden onset hearing loss (**NOT** related to ear infection/fluid)
- ☐ Lab proven meningitis or CMV
- ☐ Recent ear and/or head trauma, specify:

- ☐ Other:

NAME OF REFERRAL SOURCE	SIGNATURE
ADDRESS/AGENCY	TELEPHONE

RELATIONSHIP OF REFERRAL SOURCE TO PATIENT

☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ ENT ☐ PEDIATRICIAN ☐ SLP ☐ PHN

☐ AUDIOLOGIST ☐ TEACHER ☐ TDHH ☐ IDP/CDC ☐ OTHER: