DEPARTMENT OF AUDIOLOGY
144 Brock St., Hotel Dieu Hospital site
Murray Building

REFERRAL FORM
Phone: 613-546-3382 Fax: 613-544-5280
Website: www.KingstonHSC.ca

Date of Referral: ______________________ (yyyy/mm/dd)

This patient requires an Interpreter □ ASL □ Language __________________________

The following boxes must be checked before an appointment will be booked:
□ Yes, the patient is able to provide consent. If no, please ensure a SUBSTITUTE
DECISION MAKER or a SIGNED CONSENT accompanies the patient.
□ Ear canals free of wax.
□ Veterans Affairs Canada/ Dept. of National Defence (VAC/DND) (Bring Blue Cross card)
□ Workplace Safety and Insurance Board (WSIB) (Bring claim number and Social Insurance Number)

Please check all desired assessment(s) and fax this form to 613-544-5280
□ Audiology Assessment – OHIP Covered
□ Auditory Brainstem Response Test – OHIP Covered
□ Hearing Aid Evaluation – $90.00 Fee
□ Hearing Aid Follow Up Only – $60.00 Fee
□ VNG/ENG (Vestibular Testing) – OHIP Covered (Completed Requisition Required)
□ Employment Audiogram – Please bill __________________________

Please check presenting symptoms:
□ Hearing Loss
□ Tinnitus
□ Middle Ear Dysfunction
□ Noise Induced Hearing Loss (patient must be out of noise 12 hours prior to appointment)
□ Autism □ Developmental Delay □ Behavioural Issues
□ Other: ________________________________________________
□ Mobility or Vision Problems ________________________________________________

Appointment Date: ____________________________ Appointment Time: __________
    yyyy/mm/dd                             hh:mm