





CR #:

**Patient Name:** 

Date of Birth: Address:

Postal Code:

Home:

Alternate:

Phone #

HCN #:

## **DEPARTMENT OF AUDIOLOGY**

144 Brock St., Hotel Dieu Hospital site Murray Building

## **REFERRAL FORM**

<b>Phone:</b> 613-546-3382 <b>Fax:</b> 613-544-5280 Website: www.KingstonHSC.ca			Family Physician: Referring Physician: Physician's Fax:
Date of Referral:(уууу		_(yyyy/mm/dd)	Physician's Address:
This patient	requires an Interpreter:	□ ASL	□ Language
The following			ppointment will be booked:
			nt. If no, please ensure a SUBSTITUTE
	Ear canals free of wax	IGNED CONS	ENT accompanies the patient.
		Dent of Nation	nal Defence (VAC/DND) Bring Blue Cross card
	Workplace Safety and Insurance Board (WSIB) Bring claim number and Social Insurance Number		
Please chec	k all desired assessment	(s) and fax thi	s 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 – \$75.00 Fee		
	VNG/ENG (Vestibular Testing) – OHIP Covered (Completed Requisition Required) Employment Audiogram – Please bill:		
Please chec	ck presenting symptoms:		
	Hearing loss		
	Tinnitus		
	Middle ear dysfunction		
	Noise Induced Hearing Los	SS (patient must l	be out of noise <b>12 hours</b> prior to appointment)
Relevant inf			
			□ Cognitive delay □ Behaviour concerns
	Speech and/or language delay/disorder		
	Motor/mobility concerns		
	Other:		
Ц	Outer.		
Comments:			

**Appointment Date:** 

yyyy/mm/dd

hh:mm

**Appointment Time:**