Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

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)

CR #:
Patient Name:
Date of Birth:
Address:

Postal Code:
Phone # Home:
Alternate:
HCN #:

Family Physician:
Referring Physician:
Physician's Fax:
Physician's Address:

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 – $120.00 Fee
- □ Hearing Aid Follow Up Only – $100.00 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)

Relevant information:

- □ Autism □ Developmental delay □ Cognitive delay □ Behaviour concerns
- □ Speech and/or language delay/disorder
- □ Motor/mobility concerns
- □ Vision concerns: _____
- □ Other: _____

Comments: _____

_____

Appointment Date: _____ **Appointment Time**: _____
yyyy/mm/dd hh:mm