(For office use only)
Date received stamp

Referral #

AUDIOLOGY REFERRAL FORM

Hearing Assessment for Children

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

PLEASE PRINT Please ***complete all sections*** of this form. **Incomplete forms will be returned.**

Section 1: Patient Information			
Patient's Last Name	**Patient's First Name**	**Patient's Date of Birth (dd/mm/yyyy)**	**Home Phone** *(include area code)*
Address Building Number Street Name Suite/Apt Number City/Town Province Postal Code			**Cell or Work Phone** *(include area code)*
Gender ☐ Male ☐ Female ☐ Other	**Language** ☐ English ☐ French ☐ Other ___________	**Is an Interpreter Required?** ☐ Yes ☐ No	**Health Card Number**

Section 2: Reason for Referral

Please check ALL relevant boxes. Provide any additional information in the comments section below.

☐ Middle ear problems; history of recurrent otitis media

☐ Ear and/or head trauma

☐ Meningitis

☐ Cytomegalovirus (CMV)

☐ Sudden onset hearing loss

☐ Suspected hearing loss, NOT related to middle ear fluid/infection

We do not offer hearing screenings at CHEO;
→If Ontario resident: Child can be screened by Infant Hearing Program **before** 2 months of age. Please call IHP at 613-688-3979.

☐ Speech and language concerns

☐ Parental concern re: hearing difficulties

☐ School concern re: hearing difficulties or learning difficulties

☐ Pre/post-surgery hearing test

☐ Hearing Re-assessment

☐ ASD, cognitive impairment

☐ Hearing Aid selection, fitting, or evaluation Does child presently wear hearing aid(s) or other hearing devices? ☐ Yes ☐ No

Comments:

PLEASE PRINT. Please attach office letterhead, or complete Section 3. FAX COMPLETED FORM TO: 613-738-4222.

Section 3: Referral Source		
☐ **Family Doctor** ☐ **ENT** ☐ **Pediatrician** ☐ **Nurse Practitioner** ☐ **Speech-Language Pathologist (SLP)** ☐ **Audiologist**		
Name (Last Name) (First Name)	**Phone** *(include area code)*	**Fax** *(include area code)*
Address Building Number Street Name Suite/Apt Number City/Town Province Postal Code		
Provider #	**Signature**	

***** Please note that CHEO Audiology specializes in services for all children ages 0-6 years and children with special needs ages 0-18 years. Should you require testing for a child outside of this scope, please consult a community audiologist *first* for an expedited visit. Thank you. *****

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