

# Interprofessional Clinic Clinique Interprofessionnelle



## Referral Form - Audiology Services

**\*The Interprofessional Clinic is a teaching clinic. As such, most services are offered by students under the supervision of a clinical educator. In all cases, the supervisors are registered members of their respective college. It is possible that students observe the sessions.**

Fax # 613-526-7126

### Client's personal information

Given name	Last name	Date of birth (dd/mm/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Address	Apt.	City	Province	Postal Code
Home telephone #	<input type="checkbox"/> Work or <input type="checkbox"/> cell telephone #	Languages spoken by the client: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify)		

### Substitute-decision maker

Given name	Last name	Relationship to client
Telephone # to book appointments		Preferred language <input type="checkbox"/> English <input type="checkbox"/> French

### Reasons for referral (Select all that apply)

<input type="checkbox"/> Infant screenings (0 - 6 months)	<input type="checkbox"/> Speech or language concerns
<input type="checkbox"/> Peripheral hearing assessment- to rule out hearing loss (6 months+)	<input type="checkbox"/> Sudden onset of hearing loss (within the last <b>24-48hrs</b> )
<input type="checkbox"/> CAPD-Central Auditory Processing Disorder assessment (7yrs +)	<input type="checkbox"/> School concerns, learning difficulties
<input type="checkbox"/> Parental concerns re: hearing difficulties	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Suspected hearing loss, <b>not</b> related to middle ear fluid/infection	<input type="checkbox"/> Hearing aid evaluation
<input type="checkbox"/> Hearing re-assessment	<input type="checkbox"/> Earwax/cerumen management
<input type="checkbox"/> Middle ear problems; history of recurrent otitis media	<input type="checkbox"/> Other (specify)
Does the client wear hearing aids? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Is your referral related to a specific diagnosis or any specific observations? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify)	

### Source of referral (How did you hear about the clinic?)

<input type="checkbox"/> OCTC	<input type="checkbox"/> First words	<input type="checkbox"/> CHEO	<input type="checkbox"/> School	<input type="checkbox"/> LHIN
<input type="checkbox"/> Family doctor	<input type="checkbox"/> Self-refer	<input type="checkbox"/> Other (specify)		

### Family Doctor

### Referring Healthcare Provider

First & Last Name	First & Last Name
Address	Address
Telephone #	Telephone #