# Interprofessional Clinic
# Clinique Interprofessionnelle

Perley Health

## Referral Form - Audiology Services

**Fax # 613-526-7126**

### Client's personal information

| | | | | |
|---|---|---|---|---|
| Given name | Last name | Date of birth (dd/mm/yyyy) | Age | Gender ☐ M ☐ F ☐ Other |
| Address Apt. City Province Postal Code | | | | Preferred Pronouns |
| Home telephone # | ☐ Work or ☐ cell telephone # | Languages spoken by the client: ☐ English ☐ French ☐ Other (specify) | | |
| Insurance Coverage: ☐ HCAI ☐ WSIB ☐ ODSP ☐ Private Insurance. If private insurance please specify: | | | | |

### Substitute-decision maker

| | | |
|---|---|---|
| Given name | Last name | Relationship to client |
| Telephone # to book appointments | | Preferred language ☐ English ☐ French |

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

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

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

| | | | | |
|---|---|---|---|---|
| ☐ OCTC | ☐ First words | ☐ CHEO | ☐ School | ☐ LHIN |
| ☐ Family doctor | ☐ Self-refer | ☐ Other (specify) | | |

### Family Doctor

| |
|---|
| First & Last Name |
| Address |
| Telephone # |

### Referring Healthcare Provider

| |
|---|
| First & Last Name |
| Address |
| Telephone # |