REQUEST FOR HEARING/SPEECH SERVICES

PHN# ______________________________

NAME OF CHILD ______________________________ **DOB: (m/d/y)**______________________________

Please write out the month/day/year

PARENT/GUARDIAN ______________________________

STREET ______________________________

CITY ______________________________ **POSTAL CODE** ____________________

TELEPHONE (HOME) ______________________________ **WORK/CELL** ______________________________

DETAILED DESCRIPTION OF CONCERN, DIAGNOSIS, PERTINENT PHYSICAL FINDINGS, BRIEF HISTORY OR COMMENTS (REQUIRED).

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HEARING EVALUATION ☐ **SPEECH & LANGUAGE ASSESSMENT** ☐

PREVIOUS PHYSICIAN, SPECIALIST OR CLINIC ATTENDED

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REFERRED BY ______________________________ **DATE** ______________________________

TITLE

PUBLIC HEALTH NURSE ☐ PHYSICIAN ☐ AUDIOLOGIST ☐ SPEECH-LANGUAGE PATHOLOGIST ☐ OTHER ☐

ADDRESS ______________________________

Clinic name: ______________________________

VANCOUVER ISLAND HEALTH AUTHORITY
SPEECH & HEARING CLINIC
104 – 501 Fourth Street
COURTENAY BC V9N 1H3

Telephone 250-331-8526 Fax 250-331-8527