island health

REFERRAL FOR HEARING SERVICES

LAST NAME FIRST NAME	☐ MALE ☐ FEMALE ☐ OTHER:	DATE OF BIRTH (DD/MM/YYYY)
PREFERRED NAME / PRONOUNS (if applicable):		PERSONAL HEALTH NUMBER
ADDRESS (Including postal code)		PHYSICIAN / NURSE PRACTITIONER (include initials)
PREFERRED PHONE NUMBER:		DOES CLIENT RECEIVE BC DISABILITY BENEFITS: ☐Yes ☐No
PARENT / GUARDIAN NAME: _____ PHONE (If different from above):_____ ALTERNATE NUMBER / EMAIL:_____		SCHOOL (IF APPLICABLE)
PARENT / GUARDIAN NAME: _____ PHONE (If different from above):_____ ALTERNATE NUMBER / EMAIL:_____		HAS PARENT / GUARDIAN BEEN NOTIFIED OF REFERRAL: ☐Yes ☐No

REFERRED FOR:
☐ AUDIOLOGICAL EVALUATION (INCLUDING HEARING AID FITTING IF APPLICABLE)
☐ KINDERGARTEN HEARING SCREENING (IF NOT COMPLETED AT SCHOOL)
☐ NEWBORN HEARING SCREENING (BABY UNDER 6 MONTHS OLD)
☐ OTHER:

REASON FOR REFERRAL/PERTINENT MEDICAL OR DEVELOPMENTAL HISTORY AND COMMENTS:

☐ HEARING CONCERNS: _____

☐ HEARING LOSS RISK FACTORS: _____

☐ SPEECH/LANGUAGE CONCERNS: _____
☐ PSYCHOEDUCATIONAL ASSESSMENT
☐ AUTISM: ☐ SUSPECTED ☐ DIAGNOSED
☐ OTHER: _____

NAME OF REFERRAL SOURCE	SIGNATURE
ADDRESS/AGENCY	Date

RELATIONSHIP OF REFERRAL SOURCE TO PATIENT
☐ PARENT/GUARDIAN ☐ SELF ☐ PHYSICIAN / NP ☐ ENT ☐ PEDIATRICIAN ☐ SLP ☐ PHN
☐ AUDIOLOGIST ☐ TEACHER ☐ TDHH ☐ QACCH ☐ OTHER:

Island Health
☐ Victoria Health Unit 1947 Cook Street Victoria, BC V8T 3P7 Phone: 250-388-2250 Fax: 250-388-2272
☐ West Shore Health Unit 345 Wale Road Victoria, BC V9B 6X2 Phone: 250-519-3490 Fax: 250-519-3491