AUDIOLOGY SCHOOL AGE & ADULT REFERRAL FORM

❑ **Stephenville**
127 Montana Drive
Stephenville, NL A2H 2T4
T: 709–643–8690
F: 709–643–3944
(includes Port Aux Basque Clinics)

❑ **Corner Brook**
P.O. Box 2005
Corner Brook, NL A2H 6J7
T: 709–784–5374/709–784–6155
F: 709–637–5381
(includes Norris Point Clinics)

CLIENT INFORMATION: (please print and complete ALL information below)

Name: ______, ______________ (last) (first) (middle)
DOB: ________/________/________ yyyy mm dd

Address: ____________________
Postal Code: ____________________

Telephone: ____________________
Gender: ____________________

MCP: ____________________
NOK: ______, ______________

PRESENTING CONCERNS: (please check/complete all that apply to help up prioritize properly)

❑ **Difficulty Hearing**	Bilateral? ❑ Yes ❑ No	Serious safety concern ❑ Yes ❑ No
❑ **Sudden Hearing Loss**	Date of Onset ____________	Still Present? ❑ Yes ❑ No
❑ **Ear Infections**		
❑ **Wax Buildup**	Removed? ❑ Yes ❑ No	If yes, when ____________
❑ **Vertigo/Dizziness/Off Balance**	Date of Onset ____________	Still Present? ❑ Yes ❑ No
❑ **Ear Surgery**	Date ____________	Ear ❑ Left ❑ Right
❑ **Family Hx Hearing loss**	Who ____________	
❑ **Trauma/Injury to Ears**	Date ____________	
❑ **Ototoxicity**	Date Exposed ____________	
❑ **Tinnitus/Buzzing/Ringing**	Constant? ❑ Yes ❑ No Impacting Life? ❑ Yes ❑ No	Bilateral? ❑ Yes ❑ No
❑ **Other**		

Does client have an appointment with ENT physician? ❑ Yes ❑ No
ENT Name: ____________________ ENT Appt Date: ____________________

EXAMINATION REQUESTED: ❑ **Hearing Assessment** ❑ **ABR** ❑ **VNG (ENT referral only)**

REFERRAL DATE: ____________________ REFERRAL SOURCE: ____________________

REFERRAL ADDRESS: ____________________ POSTAL CODE ____________ TELEPHONE: ____________________

COPY REPORT TO: ____________________

FOR OFFICE USE ONLY:
PRIORITY STATUS: ____________________ APPOINTMENT DATE/TIME: ____________________
CRMS #: ____________________ COMMENTS: ____________________

Revised 10 / 2018