Audiology Department
P.O. Box 2005
Corner Brook, NL A2H 6J7

Telephone:(709) 637-5374 *Fax:(709) 637-5381*

CLIENT INFORMATION: (please print ALL information below)

NAME:_____ GENDER: ( ) male ( ) female
(Last) (first) middle

ADDRESS: _____ POSTAL CODE: _____

_____ TELEPHONE: _____(h)

MCP: _____ TELEPHONE: _____(o)

NOK: _____ DOB: _____/_____/_____

□ DVA □ WCC □ MEDICAL

REFERRAL INFORMATION: (please fill in ALL information)

□ Ear Infections □ Pain in ears □ Difficulty hearing □ Ear Surgery

□ Family Hx Hearing Loss □ Wax Buildup □ Tinnitus/buzzing/ringing □ Ototoxicity

□ Sudden Hearing Loss □ Trauma/Injury to Ears □ Vertigo/Dizziness/Off Balance

□ Occupational/Recreational Noise Exposure □ Other (Please Specify) _____

COMMENTS:_____

Does client have an appointment with ENT physician? □ Yes □ No ENT appointment time_____

EXAMINATION REQUESTED: □ ENG □ Calorics □ OAE

□ Audiogram □ Tympanogram □ART □ ABR □ Hearing Aid Assessment

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REFERRAL DATE: _____ REFERRAL SOURCE: _____

REFERRAL ADDRESS: _____

POSTAL CODE: _____ TELEPHONE: _____

COPY REPORT TO: _____

FOR OFFICE USE ONLY:

APPOINTMENT DATE:_____ TIME:_____

PRIORITY STATUS: _____ COMMENTS:_____

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