Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

8589

MRN #:
FIN#
Patient Name:
Date of Birth:
Address:

Postal Code:
Phone # Home:
Alternate:
HCN #:

Family Physician:
Referring Physician:
Physician's Fax:
Physician's Address:

DEPARTMENT OF AUDIOLOGY
144 Brock St., Hotel Dieu Hospital site
Murray Building

REFERRAL FORM
Phone: 613-546-3382 **Fax:** 613-544-5280
Website: www.KingstonHSC.ca

Date of Referral: _____(yyyy/mm/dd)

This patient requires an Interpreter: □ ASL □ Language _____

The following boxes must be checked before an appointment will be booked:

- □ Yes, the patient is able to provide consent. If no, please ensure a SUBSTITUTE DECISION MAKER or a SIGNED CONSENT accompanies the patient.
- □ Ear canals free of wax
- □ Veterans Affairs Canada/ Dept. of National Defence (VAC/DND) Bring Blue Cross card
- □ Workplace Safety and Insurance Board (WSIB) Bring claim number and Social Insurance Number

Please check all desired assessment(s) and fax this form to 613-544-5280

- □ Audiology Assessment – OHIP Covered
- □ Auditory Brainstem Response Test – OHIP Covered
- □ Hearing Aid Evaluation – $90.00 Fee
- □ Hearing Aid Follow Up Only – $75.00 Fee
- □ VNG/ENG (Vestibular Testing) – OHIP Covered ***(Completed Requisition Required)***
- □ Employment Audiogram – Please bill: _____

Please check presenting symptoms:

- □ Hearing loss
- □ Tinnitus
- □ Middle ear dysfunction
- □ Noise Induced Hearing Loss (patient must be out of noise **12 hours** prior to appointment)

Relevant information:

- □ Autism □ Developmental delay □ Cognitive delay □ Behaviour concerns
- □ Speech and/or language delay/disorder
- □ Motor/mobility concerns
- □ Vision concerns: _____
- □ Other: _____

Comments: _____

_____

Appointment Date: _____ **Appointment Time**: _____
yyyy/mm/dd hh:mm