HUMBER RIVER HOSPITAL

Maternal & Child Program

AUDIOLOGY REFERRAL FORM

Out-Patient Paediatrics
1235 Wilson Avenue, 4th Floor, Toronto, Ontario, M3M 0B2
Phone# 416-242-1000 ext. 21400 Fax# 416-242-1095

Patient Information

Surname		Given Names
Date of Birth	Sex M ☐ F ☐	Health Card No.
Address & Telephone Numbers		

Reason for Referral –Relevant Clinical History/Comments

Tests Ordered

- ○ Pure Tone Audiometry with Speech
- ○ ABR Testing (Auditory Brainstem Response)
- ○ Sound Field Testing
- ○ Impedance Audiometry/Compliance
- ○ Hearing Aid Check/Evaluation (Fees Apply)
- ○ Other Advanced Testing

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Referring Practitioner Information

Physicians Name/Signature:

Date and Time of Appointment