Interlake–Eastern
Regional Health Authority

Beausejour Audiology
Primary Health Care Centre
Ph: (204) 268-7465 Fax: (204) 482-2003

Selkirk Audiology
100 Easton Drive, Selkirk, MB
Ph: (204) 785-7403 Fax: (204) 482-2003

REQUIRED INFORMATION		
REFERRAL DATE		
LAST NAME		MALE ☐ FEMALE ☐ NOT DISCLOSED ☐
FIRST NAME		
BIRTH DATE (DDMMYYYY)		
MAILING ADDRESS		
CITY		**PC**
PARENT/GUARDIAN		
HOME PHONE		
WORK PHONE		**CELL:**
MHSC#		**PHIN#**
PHYSICIAN:		
TELEPHONE:		**FAX:**

AUDIOLOGY REFERRAL			
Referral Source			
Address			
Postal Code			
Phone :		**Fax :**	

Has this client been seen at THIS CLINIC before? ☐ **Yes** ☐ **No** **If 'YES' Date Last Seen:**

SERVICES FOR ADULTS 21 AND OLDER (IF UNDER 21 YRS OF AGE COMPLETE CTI REFERRAL FORM)

REASONS FOR REFERRAL: (Check all that apply)

☐ Sudden Onset Hearing Loss Date: ☐ Unilateral Hearing Loss R: ☐ L: ☐	☐ Head or Ear Trauma: Details:	☐ Previous Consultation with ENT: Details:
☐ Rule Out Retrocochlear Pathology	☐ Chemotherapy/Ototoxic Monitoring Details:	☐ ENT Referral Made: ☐ NO ☐ YES Date: Name of ENT:
☐ Pre-operative Assessment Date: Surgery Type:	☐ Acute Middle Ear Issues: ☐ Muffled Speech ☐ Aural Fullness	☐ BPPV Diagnosis Date:
	☐ Chronic Middle Ear Issues ☐ Tympanic Membrane Perforation ☐ Ear Discharge	☐ Vestibular Concerns ☐Vertigo ☐Nausea ☐Dizziness
☐ Post-operative Assessment Date: Surgery Type:	☐ Hearing Loss Questioned: ☐ Tinnitus: ☐ Unilateral ☐ Bilateral ☐ History of Noise Exposure	Medical Conditions: ☐ Diabetes ☐Cancer Diagnosis ☐Hypertension ☐Other Details:
☐ Family History of Hearing Loss:	**MUST BE COMPLETED** ☐ **Hearing Aid User** ☐ **YES** ☐ **NO** **R:** ☐ **L:** ☐ **Both:** ☐	Other Concerns:

COMMENTS:

Date referral received by audiology:	Date receipt of referral confirmation sent to client: