



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 <input type="checkbox"/> FEMALE <input type="checkbox"/> NOT DISCLOSED <input type="checkbox"/>	
FIRST NAME			
BIRTH DATE (DDMMYYYY)			
MAILING ADDRESS			
AUDIOLOGY REFERRAL		CITY	PC
Referral Source	PARENT/GUARDIAN		
Address	HOME PHONE		
	WORK PHONE		CELL:
Postal Code	MHSC#		PHIN#
Phone :	Fax :	PHYSICIAN:	
	TELEPHONE:		FAX:
Has this client been seen at <u>THIS CLINIC</u> before? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		
<input type="checkbox"/> Sudden Onset Hearing Loss Date:	<input type="checkbox"/> Head or Ear Trauma: Details:	<input type="checkbox"/> Previous Consultation with ENT: Details:
<input type="checkbox"/> Unilateral Hearing Loss R: <input type="checkbox"/> L: <input type="checkbox"/>		
<input type="checkbox"/> Rule Out Retrocochlear Pathology	<input type="checkbox"/> Chemotherapy/Ototoxic Monitoring Details:	<input type="checkbox"/> ENT Referral Made: <input type="checkbox"/> NO <input type="checkbox"/> YES Date: Name of ENT:
<input type="checkbox"/> Pre-operative Assessment Date: Surgery Type:	<input type="checkbox"/> Acute Middle Ear Issues: <input type="checkbox"/> Muffled Speech <input type="checkbox"/> Aural Fullness	<input type="checkbox"/> BPPV Diagnosis Date:
	<input type="checkbox"/> Chronic Middle Ear Issues <input type="checkbox"/> Tympanic Membrane Perforation <input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Vestibular Concerns <input type="checkbox"/> Vertigo <input type="checkbox"/> Nausea <input type="checkbox"/> Dizziness
<input type="checkbox"/> Post-operative Assessment Date: Surgery Type:	<input type="checkbox"/> Hearing Loss Questioned: <input type="checkbox"/> Tinnitus: <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral	Medical Conditions: <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer Diagnosis <input type="checkbox"/> Hypertension <input type="checkbox"/> Other
	<input type="checkbox"/> History of Noise Exposure	Details:
<input type="checkbox"/> Family History of Hearing Loss:	MUST BE COMPLETED <input type="checkbox"/> Hearing Aid User <input type="checkbox"/> YES <input type="checkbox"/> NO R: <input type="checkbox"/> L: <input type="checkbox"/> Both: <input type="checkbox"/>	Other Concerns:
COMMENTS:		
Date referral received by audiology:	Date receipt of referral confirmation sent to client:	