



Interlake-Eastern  
Regional Health Authority

**Audiology Department**  
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AUDIOLOGY REFERRAL

Referral Source \_\_\_\_\_

Address \_\_\_\_\_

PC \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

REQUIRED INFORMATION

REFERRAL DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ MALE   
FEMALE

FIRST NAME \_\_\_\_\_

BIRTH DATE D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ PC \_\_\_\_\_

PARENTS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

WORK PHONE \_\_\_\_\_

MHSC# \_\_\_\_\_ PHIN# \_\_\_\_\_

ADDITIONAL INFORMATION IF APPLICABLE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

SCHOOL \_\_\_\_\_

Has this client been seen at THIS CLINIC before?  Yes  No Date \_\_\_\_\_

**SERVICES FOR CHILDREN**

**RISK FACTORS FOR PERMANENT CONGENITAL, DELAYED ONSET/PROGRESSIVE HEARING LOSS**

- Parental concerns
- Family history of childhood hearing loss
- NICU >5 days
- ECMO or IPPV for any length of time
- Ototoxic medications above therapeutic levels
- Jaundice requiring exchange transfusion
- TORCHS
- Craniofacial abnormalities
- Chemotherapy
- Syndrome associated with hearing loss
- \_\_\_\_\_
- Neurodegenerative disorder
- \_\_\_\_\_
- Postnatal infections such as bacterial/viral meningitis
- Head trauma – skull fracture, birth asphyxia or brain hemorrhage

**CHECK OTHER CONCERNS:**

- Hearing Loss Questioned
- Unable to follow simple directions
- No response to loud sounds
- Developmental Delay
- Autistic or PDD Features

**CHILD HAS BEEN REFERRED FOR SPEECH**

- No speech
- Speech or Language Delay
- Failed School screening
- Visual Impairment

**SERVICES FOR ADULTS**

**REASONS FOR REFERRAL: (Check all that apply)**

- Sudden Onset Hearing Loss  
Date \_\_\_\_\_
- Unilateral Hearing Loss
- Rule out retrocochlear pathology
- Head or ear trauma
- Pre-operative assessment  
Date \_\_\_\_\_  
Surgery Type \_\_\_\_\_
- Post-operative assessment  
Date \_\_\_\_\_  
Surgery Type \_\_\_\_\_
- Hearing loss questioned
- Tinnitus:  Unilateral  Bilateral
- Vestibular concerns
- History of noise exposure
- Family history of hearing loss
- To initiate a WCB or VAC (DVA) claim
- Audiogram required for a medical

**COMMENTS:** \_\_\_\_\_

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