Referral for Audiology Services
Department of Speech and Hearing

Name: **Sex:**	**Date of Birth:**
Address:	**Physician:**
Postal Code:	**Copies to:**
Medicare #:	**Reason for referral:**
Parent/Guardian:	
Phone: Home: **Work:**	
Language preference: ☐ English ☐ French	

Service requested: ☐ Hearing Test ☐ABR ☐Other:_____

ENTs only

ENG: *Check only tests you are requesting*

Standard ENG Tests:
- ☐ **Calorics**
- ☐ **Gaze testing**
- ☐ **Smooth pursuit**
- ☐ **Saccade testing**

Additional Special Tests:
- ☐ **Positionals**
- ☐ **Optokinetics**

Priority: ☐ High ☐Med ☐Low

Please complete the following questionnaire. Your doctor is referring you or your child for a hearing test and this information will help us provide you with a better service.

Which ear has been the problem? ☐Right ☐Left ☐Both
Was the hearing loss ☐sudden or ☐gradual?
Has there been a hearing test before? ☐No ☐Yes If yes, where? _____
Have hearing aids ever been worn? ☐No ☐Yes If yes, please provide more information:
_____

Please circle all appropriate answers:

Recent ear infections?	Yes	No	Right Ear	Left Ear
Frequent ear infections?	Yes	No	Right Ear	Left Ear
Pain in ears?	Yes	No	Right Ear	Left Ear
Discharge from ears?	Yes	No	Right Ear	Left Ear
Operations on ears?	Yes	No	Right Ear	Left Ear
Sounds heard in the ears (buzzing, ringing etc)?	Yes	No	Constant	Occasional
Sounds in which ear	Right	Left	Both	
Dizziness or light-headedness?	Yes	No	Frequent	Occasional
Problems keeping balance?	Yes	No	Frequent	Occasional

Has anyone in the immediate family had a hearing loss as a child requiring hearing aids?
☐No ☐Yes If yes please specify (aunt, uncle, mother, father, brother etc).

_____

Please check any of the following that might have happened.
☐ skull fracture ☐severe blow to the head ☐numbness ☐ blurred or double vision
☐facial pain or spasms ☐ facial weakness ☐ difficulties talking or swallowing

Please list all current medications (including over-the-counter);_____
_____
_____
_____

Has there been any exposure to noisy activities such as:
☐hunting ☐target shooting (☐right shot or ☐left shot) ☐playing musical instruments
☐riding motorcycles or ATVs ☐ snowmobiling ☐ military service ☐occupational noise (construction, factory work, mechanical work) ☐Other ?_____

Has an ear, nose and throat (ENT) specialist been seen? ☐No ☐Yes If yes, for what reason?
_____

In which way have activities and everyday life been affected by your problem?
_____
_____
_____
_____

Please also fill out the following questions if referral is for an infant or child

Has your child's hearing been screened at birth or by Public Health (preschool clinic)?
☐Yes ☐No.
If yes, what were the results? ☐pass ☐fail ☐don't know

What problems or behaviors have caused concerns with regards to your child's hearing (example: speech delay, often asks you to repeat)?
_____
_____

Is any appointment time or day better for you to attend?
_____
_____

Is there any other information you feel we should know?
_____
_____
_____

_____ _____
Signature **Date**