Hamilton Health Sciences – RJCHC
AUDIOLOGY
325 Wellington St. North
Phone: (905) 521-7951 Fax: (905) 521-4994

Referral Form - Professional

Date of Request YY MM DD

Male ☐ **Female** ☐

Client's Name: LAST NAME FIRST NAME

Date of Birth: YY MM DD **H.I.N.** **Version Code**

Address:

City: **Postal Code:**

Home Phone: **Cell Phone:**
Work Phone:

Reason for Referral: (Please describe the concerns for this client. Include any relevant documentation.)

Other relevant diagnoses or conditions, allergies:

Referral Source name & address:	**Signature:**
Phone: **Email:**	**Fax:**

Physician's OHIP Billing Number: (if applicable) **Physician's Signature**

OHIP regulations stipulate that requests for physician consultations must be provided in writing by a physician

Office use only:

Appt booked: _____ **at** _____
Date Time

PLEASE NOTIFY PATIENT