Hamilton Health Sciences

Voice Clinic Referral Request

McMaster Children's Hospital Site - 3V1 / ENT Clinic
PHONE: 905-521-2100 Ext. 77065

Please fax referral request and copies of recent consult notes (if available) to:

905-521-8552 – **Attention: SLP**

Patient's Last Name First Name

Address – Street City Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) Age Gender ☐ M ☐ F

HIN Family Physician

Referral Date (yyyy/mm/dd) _____

If Parent / Guardian involved in client's care:

Name _____ Phone _____

Referring Physician (print) _____

Phone _____ (ext) _____

Fax _____

Referring Physician Signature _____

OHIP Billing Number _____

Medical History: _____

_____

_____

Vocal fold lesion description: _____

_____

_____

Voice Problem: _____

_____

_____

Resonance Problem: ☐ No ☐ To much nasality ☐ To little nasality ☐ Not sure

Priority - Explain: _____

_____

Professional Voice User? ☐ Yes ☐ No Explain: _____

_____

Comments: _____

_____

SLP Impression/Observation of issue: _____

_____

_____

SPL Printed Name _____ SLP Signature _____