McMaster Children's Hospital
RON JOYCE CHILDREN'S HEALTH CENTRE

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

Referral Form – Professional Audiology Clinic & Dispensary

Date of Referral: _____ (YYYY / MM / DD) ☐ Male ☐ Female ☐ Intersex ☐ Prefer Not to Answer

Client's Name: (Last Name) _____ (First Name) _____

Guardian's Name: (Last Name) _____ (First Name) _____

Date of Birth: _____ (YYYY / MM / DD) Health Card Number: _____ Version Code: _____

Address: _____ (Street Name and Number) _____ (City) _____ (Postal Code)

Home Phone: _____ Cell / Work Phone: _____

REASON FOR REFERRAL (Check All That Apply) ☐ URGENT ☐ ROUTINE

PEDIATRIC	ADULT
☐ Delayed Speech & Language Development	☐ Sudden Onset Hearing Loss
☐ Autism → ☐ Diagnosed ☐ Query	☐ Asymmetrical Hearing Loss
☐ Waitlist for Developmental Pediatrician	☐ Tinnitus → ☐ Bilateral ☐ Unilateral ☐ Pulsatile
☐ Family History of Hearing Loss (Congenital)	

PEDIATRIC AND ADULT

- ☐ Query Hearing Loss
- ☐ History of Ear Infections / Fluid
- ☐ Perforated Tympanic Membrane
- ☐ Brain Injury / Head Trauma / Stroke
- ☐ Ototoxic Medication
- ☐ Wax Removal

REFERRAL TO OTOLARYNGOLOGY: ☐ Sent ☐ Pending ☐ N/A

DID THE CHILD: ☐ Pass Newborn Hearing Screen ☐ Refer Newborn Hearing Screen ☐ Unknown Result / Did Not Complete Newborn Hearing Screen

OTHER IMPORTANT INFORMATION: ☐ Interest in Purchasing Hearing Aids

☐ Currently Wearing Hearing Aids ☐ Patient Requires Interpreter – (Language) _____

☐ Other (please specify): _____

Referring Provider/Physician: _____

Address: _____ Phone: _____

Email: _____ Fax: _____

OHIP Billing Number: _____ Provider/Physician Signature: _____