Alberta Health Services

Affix patient label within this box

Community Audiology Referral

Fax completed form to **403.955.8501**

Patient will be contacted by phone to arrange appointment

Please note that incomplete or illegible referrals will be returned. Call 403.955.8500 for more information

Patient Information

Last Name	First Name		PHN
Date of Birth *(yyyy-Mon-dd)*	Address	City/Town	Postal Code
Parent/Guardian *(if applicable)*		Home Phone	Alternate Phone

Interpreter required?

☐ No ☐ Yes, specify language _____

Referral Information

Appointment Type

☐ Audiological Assessment (all ages; ABR for infants younger than 6 months)

☐ Sudden Hearing Loss (onset within 7 days)

Date of onset: _____

☐ Oncology (baseline/monitoring)

☐ Adult Neurologic ABR ***(ENT referral only)***

☐ Vestibular Evoked Myogenic Potential (VEMP) ***(ENT/Neurology referral only)***

☐ Videonystagmography (VNG) ***(ENT/Neurology referral only)***

☐ Cochlear Implant Assessment (for patients 18 years of age or older) ***(ENT/Audiologist referral only)***

Tentative diagnosis/reason for referral

Medical History *(please include all relevant information available)*

Audiological History *(please include information regarding previous hearing tests and latest available audiogram)*

Referral Source

Referral Date *(yyyy-Mon-dd)*	Physician Name *(print)*		Signature
Practice ID	Fax	Phone	Address