

Audiology Consultation

<input type="checkbox"/> Fort Saskatchewan Community Hospital <input type="checkbox"/> Grey Nuns Community Hospital <input type="checkbox"/> Leduc Community Hospital <input type="checkbox"/> Misericordia Community Hospital <input type="checkbox"/> Morinville Health Centre	<input type="checkbox"/> Northeast Community Health Centre <input type="checkbox"/> Strathcona County Health Centre <input type="checkbox"/> Sturgeon Community Hospital <input type="checkbox"/> WestView Health Centre - Stony Plain																		
Please fill out all sections of form. Incomplete referrals will be returned.																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Patient's Name</td> <td style="width: 30%;">Date of Birth (yyyy-Mon-dd)</td> <td style="width: 30%;">PHN</td> </tr> <tr> <td colspan="2">Address</td> <td>Postal Code</td> </tr> <tr> <td>Mother</td> <td>Father</td> <td>Guardian (if applicable)</td> </tr> <tr> <td>Home Phone</td> <td>Work Phone</td> <td>Cell Phone</td> </tr> <tr> <td colspan="2"> Language spoken by client <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____ </td> <td>Physician Name</td> </tr> </table>		Patient's Name	Date of Birth (yyyy-Mon-dd)	PHN	Address		Postal Code	Mother	Father	Guardian (if applicable)	Home Phone	Work Phone	Cell Phone	Language spoken by client <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____		Physician Name			
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Language spoken by client <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____		Physician Name																	
<input type="checkbox"/> Urgent Request for Audiological Assessment <input type="checkbox"/> Sudden hearing loss (acquired within past 90 days and not related to middle ear infection) <input type="checkbox"/> Pre-surgery audiogram <input type="checkbox"/> Other _____																			
<input type="checkbox"/> Routine Request for Audiological Assessment <input type="checkbox"/> Suspected hearing loss <input type="checkbox"/> No concerns; want to rule out hearing loss <input type="checkbox"/> Other _____																			
<input type="checkbox"/> Request for Audiological Review (please send results if tested previously at a different location) Date of last hearing test _____ Location of last hearing test _____ Reason for review: <input type="checkbox"/> Permanent hearing loss <input type="checkbox"/> Middle ear concerns <input type="checkbox"/> Other _____																			
<input type="checkbox"/> Request for Auditory Processing Evaluation Physician referral required and child must meet all criteria below: <ul style="list-style-type: none"> • Seven years of age or older • Full scale IQ score is 80 or higher. If full scale score is less than 80, a General Ability Index of 80 or higher is acceptable. • Copy of cognitive assessment must accompany referral • No known hearing loss • English language skills are sufficient to understand verbal instructions and provide responses • Does not present with a higher-order language deficit such as Autism Spectrum Disorder 																			
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