Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Sudden Sensorineural Hearing Loss Referral

- Submit referral by Fax: **403-592-4289**
- All referrals must include a **recent audiogram** performed after the reported hearing loss occurred.
- **Incomplete referrals will be faxed back to the referral source without being triaged**.
- Our office will contact the patient with an appointment. Please **do not call** our office for an appointment date.

Hearing Loss Date of Onset *(dd-Mon-yyyy)*	Ear(s) Affected: ☐ Left ☐ Right

Appropriate Referrals

1. Greater than 30 dB sensorineural loss less than 3 consecutive frequencies
2. Hearing loss onset less than or equal to 3 weeks (Urgent)
3. Hearing loss onset between 3 - 12 weeks (Semi-urgent)

Inappropriate Referrals

1. Greater than 30 dB sensorineural loss at greater than 3 consecutive frequencies
2. Hearing loss onset greater than 12 weeks
3. Conductive hearing loss

Patient Information

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

Interpreter required? ☐ No ☐ Yes ► Specify language _____

Medical and Audiological History

Tinnitus: ☐ No ☐ Yes ► ☐ Left ☐ Right Date of Onset *(dd-Mon-yyyy)* _____

Vertigo/Dizziness ☐ No ☐ Yes ► ☐ Episodic ☐ Constant Date of Onset *(dd-Mon-yyyy)* _____

Recent Head Injury ☐ No ☐ Yes ► Date of Onset *(dd-Mon-yyyy)* _____

Recent Ear Infection ☐ No ☐ Yes ► Date of Onset _____

Noise Exposure/History ☐ No ☐ Yes ► ☐ Work-related ☐ Recreational Number of hours/day ____

Relevant Medical History

☐ Autoimmune Disease ☐ Myocardial Infarction ☐ Cardiac History ☐ Stroke

☐ High Cholesterol ☐ Angina ☐ Other _____

Prescribed Medications *(please list all or attach list)*

*Is patient on Prednisone? ☐ No ☐ Yes ► what is the anticipated date of completion? _____

Referral Source

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