



Owen Sound Professional Centre 220-945 3rd Avenue East
Owen Sound, ON N4K 2K8
Tel 519-376-9084 Fax 519-376-7643

AUDIOLOGY REFERRAL

Name: _____

Address: _____

Phone Number: home _____ work _____

Date of Birth: _____

AUDIOLOGIST

Kristina Hill,
BA (Hons), MSc,
Reg. CASLPO

Health Card Number: _____

Family Doctor: _____ Referring Doctor: _____

Please check the appropriate box

HEARING
INSTRUMENT
SPECIALIST

Katie Troyan,
BSc (Hons), HIS

Form with columns YES and NO and checkboxes for various hearing-related questions such as 'Do you suspect the patient has a hearing loss?' and 'Does the patient own hearing aids?'.

PLEASE PROVIDE PREVIOUS AUDIOLOGICAL TESTING IF AVAILABLE

DATE: _____

Physician Signature

Please mail or fax this referral to 519-376-7643. Your patient will be notified directly of the appointment on receipt of this information.