HEAR
Owen Sound

Kristina Hill, Audiologist/Clinic Manager, BA (Hons), MSc, Reg. CASLPO 3075

Name: Date of Birth:

Phone Number: Email Address:

Health Card Number:

Family Doctor: Referring Doctor (*if different from family doctor*):

Please check the appropriate boxes

	YES	NO
Is hearing loss suspected?	☐	☐
Is the patient experiencing any of the following issues?		
sudden hearing loss (SSNHL)	☐	☐
ear infections / earaches / aural fullness	☐	☐
dizziness / balance difficulties	☐	☐
tinnitus	☐	☐
Does the patient have a history of noise exposure?	☐	☐
Has the patient ever had any surgery on their ears?	☐	☐
If yes, which procedure?		
Does the patient own hearing aids?	☐	☐
If yes, does the patient want to replace them?	☐	☐
If no, is the patient considering amplification as a treatment option?	☐	☐
Children only: Are there speech and language concerns?	☐	☐
Please include parent(s) name:		

DATE: PHYSICIAN SIGNATURE:

Please fax this referral to 519-371-6769
Your patient will be notified directly of the appointment on receipt of this information.