

REFERRAL FORM

Instructions: Fax to the Manager, Tri-Regional Infant Hearing Program at fax 905-472-7553 or mail to the address at bottom of this page to the attention of the Infant Hearing Program

REFERRAL SOURCE INFORMATION

| | |
|------------------------|-------------------|
| REFERRED BY (name): | DATE OF REFERRAL: |
| TITLE (if applicable): | TEL NO. and EXT: |
| ORGANIZATION: | FAX NO: |

CLIENT INFORMATION

Confidential

| | | |
|--|---|--------------|
| Child's Name: | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| DOB: | | |
| Mothers Name: | | |
| Father's Name: | | |
| Address of Child: | | Postal Code: |
| Day-time Telephone: | Other Tel: | |
| Did child pass the newborn infant hearing screening? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Do not know | |
| Is child currently enrolled with an Infant Hearing Program? | <input type="checkbox"/> No <input type="checkbox"/> Yes, in _____ Region | |
| Service Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (include dialect) _____ | | |

REASON FOR REFERRAL

Permanent childhood Hearing Loss identified by an audiologist
 Date of Diagnosis: _____ Name of audiologist: _____
 Attach most recent audiogram.

Child has a risk factor for permanent childhood hearing impairment
(Select from below. Please note that Otitis Media is not a risk indicator by itself.)

- Post Natal Infection associated with a hearing impairment including meningitis, viral encephalitis or Labyrinthitis Date of Diagnosis: _____
- Family History of Hearing Loss. List relationship to infant: _____
- Diagnosis of a syndrome associated with permanent hearing loss. Specify: _____
- Physician / Parental concern that infant may have permanent hearing loss
- Significant head trauma associated with loss of consciousness or skull fracture.
- Other:

PARENTAL/ GUARDIAN CONSENT:

I have received the verbal consent of the parent or legal guardian to make this referral on their behalf.

Name (print): _____

Signature: _____

REFERRAL OUTCOME:

(to be completed by Program Manager and returned to Referral Source and Family with copy to local region if admitted)

Admitted to Region: _____ Requires assessment by IHP Audiologist

Not admitted / not eligible for the following reason: