

INFANT HEARING PROGRAM REFERRAL FORM

Instructions: Fax to the 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:
I have received the verbal consent of the parent or legal guardian to make this referral on their behalf. Name (print): _____ Signature: _____	

CLIENT INFORMATION

Child's Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
DOB:			
Mothers Name:			
Father's Name:			
Address of Child:	Town:	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

<input type="checkbox"/> Baby under 4 months corrected age – request community screen
<input type="checkbox"/> Permanent childhood hearing loss identified by an audiologist Date of Diagnosis: _____ Attach most recent audiogram. Name of audiologist: _____ IHP Trained <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child has a risk factor for permanent childhood hearing loss (Select from below. Please note that otitis media is not a risk indicator by itself.) <input type="checkbox"/> Post-natal infection associated with hearing loss including meningitis, viral encephalitis or labyrinthitis. Date of Diagnosis: _____ <input type="checkbox"/> Family history of early hearing loss. List relationship to infant: _____ <input type="checkbox"/> Diagnosis of a syndrome associated with permanent hearing loss. Specify: _____ <input type="checkbox"/> Physician has identified a permanent hearing loss through assessment. <input type="checkbox"/> Significant head trauma associated with loss of consciousness or skull fracture. <input type="checkbox"/> Other factor associated with permanent childhood hearing impairment (please describe). _____

REFERRAL OUTCOME (completed by Intake Coordinator and faxed to referral source)

- Referral not accepted – reason _____
- Child under 4 months corrected – forward to Booking Clerk for community screen in Region _____
- Child under 12 months corrected – forward to Audio Booking for High Risk Surveillance & open file
- Refer to IHP audiology for PCHI confirmation – forward to Audio Booking & open pending chart
- Admit – Manager to complete Admission form (client record open)

ISCIS Entry Required: NO YES, Entered on date: _____ By: _____