SOUND HEARING

Referral Form

18A Court St N
Thunder Bay, ON
P7A 4T3
P. 807-935-8785
F. 807-577-2117

Patient's name: _____

Patient's phone #: _____

Patient's date of birth (MMM/DD/YYYY): _____ /____ /_____

Appt required: ◯ ASAP ◯ Specific Date: _____

Reason for referral:

- ☐ Puretone Audiometry
- ☐ Tympanometry
- ☐ Hearing Aid Evaluation
- ☐ Cerumen Management
- ☐ Other: _____

Referring physician/professional: _____

Referrer's phone #: _____

Referrer's fax #: _____

Would you like a report back? ◯ Yes ◯ No

Please send this form via fax to 807-577-2117 or email to info@soundhearingclinic.ca

We will contact the patient to book an appointment.