REFERRAL FORM

SOUND HEARING

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

We accept patients aged 4 years and older for hearing evaluations. If you have any questions or need further information, please feel free to contact our clinic.

Referral Date(mm/dd/yyyy)**:** _____

Appt required: ☐ **ASAP** ☐ **Specific Date:** _____

PATIENT INFORMATION			
Name			
D.O.B. (mm/dd/yyyy)			
Address			
City		**Postal Code**	
Home Phone		**Cell Phone**	

Reason for Referral:

☐ Puretone Audiometry
☐ Tympanometry
☐ Tinnitus Assessment
☐ Tinnitus Care Program
☐ Hearing Aid Evaluation
☐ Cerumen Management
☐ Other: _____

Referring 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.