vancouver coastalHealth
Promoting wellness. Ensuring care.

NORTH SHORE CHILDREN'S HEARING CLINIC
NORTH SHORE COMMUNITY HEALTH SERVICES
CENTRAL COMMUNITY HEALTH CENTRE
132 WEST ESPLANADE, 5TH FLOOR
NORTH VANCOUVER, BC V7M 1A2
TEL: (604) 983-6704; FAX: (604) 983-6839

CHILDREN'S HEARING CLINIC

REFERRAL FOR HEARING SERVICES

CHILD'S NAME: ______________________ ______________________ BIRTH DATE: ______________
(FIRST) (LAST) (MONTH / DAY / YEAR)

CHILD'S PERSONAL HEALTH NUMBER: ______________________ GENDER: ☐ Male ☐ Female

ADDRESS: ______________________ ______________________ POSTAL CODE: ______________
(STREET) (CITY)

TELEPHONE: HOME: ______________ WORK: ______________ CELL: ______________

PARENTS / GUARDIANS: ______________________ ______________________
(PARENT 1) (PARENT 2)

EMAIL:____

FAMILY PHYSICIAN:______________________ PEDIATRICIAN: ______________________

CLIENT IS COVERED BY MINISTRY OF SOCIAL DEVELOPMENT AND ECONOMIC SECURITY / MINISTRY FOR CHILDREN AND FAMILIES: ☐ YES ☐ NO

PARENT / CLIENT INFORMED OF REFERRAL (IF APPLICABLE): ☐ YES ☐ NO

REFERRED FOR:
☐ Audiology Services, including hearing evaluation and issuance of hearing aid(s) if indicated.
☐ Swim Molds

REASON FOR REFERRAL: ____
____

DEVELOPMENTAL DELAY: ____
____

SPEECH/LANGUAGE DELAY: ____
____

PERTINENT MEDICAL HISTORY / COMMENTS:
____
____

NAME OF REFERRAL SOURCE: ______________________ SIGNATURE: ______________________

AGENCY: ______________________ DATE: ______________________