Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Vancouver Public Health
Community Audiology and Speech-Language Program
Request for Services

Community Audiology Centre, 3rd Floor, 999 West Broadway, Vancouver BC V5Z 1K5
Tel: 604-659-1100 Fax: 604-659-1109

Please complete all sections of form. Incomplete referrals will be returned.

Referral Date *(dd/mmm/yyyy)*	Personal Health Number	Gender ❑ Male ❑ Female	Primary Language	Interpreter Required ❑ Yes ❑ No

Client's Last Name	Client's First Name	Date of Birth *(dd/mmm/yyyy)*

Address *(including postal code)*	Home Phone	CHA# *(office use only)*

Parent/Guardian *(last name, first name)*		Parent/Guardian *(last name, first name)*	
Cell/Work Phone	Email	Cell/Work Phone	Email
Name of School		Family Doctor's Name	

All children age 0-5 years referred to Speech-Language will also get their hearing checked. You do not need to refer separately for hearing. Please check all relevant boxes and provide as much detail as possible.

❑ Request for Speech-Language (0 to 5 years)

Children are eligible if they live in Vancouver

Reason for Referral

- ❑ Difficult to understand
- ❑ Few spoken words for age
- ❑ Difficulty forming sentences
- ❑ Difficulty understanding and responding
- ❑ Query Autism or developmental delay
- ❑ Behaviour (e.g. impulsive, difficulty socializing, aggression, tantrums)
- ❑ Stutters/repeats sounds and words
- ❑ Voice problem (e.g. hoarse voice, nasal sounding)
- ❑ Other (please specify):

_____
_____
_____

Child Care Facility Attended: _____
❑ Daycare ❑ Preschool
Date Entered Facility: _____

❑ Request for Audiology (0 to 19 years)

Rule out hearing loss

- ❑ Parental concern
- ❑ School concern
- ❑ Other, specify: _____

Regular request for Audiology Assessment

- ❑ Suspected or known hearing loss
- ❑ Middle ear
- ❑ Pre/post surgery audiogram
- ❑ Issuance of hearing aids as needed

Other risk factor for hearing loss, specify: _____

Urgent request for Audiology Assessment

- ❑ Sudden onset hearing loss (not related to middle ear fluid/infection)
- ❑ Ear and/or head trauma, specify:
- ❑ Lab proven infection *with high risk of hearing loss*:
  - o Meningitis
  - o Cytomegalovirus (CMV)

Other, specify:
_____

Risk of Violence/Aggression during appointment? ❑ Yes ❑ No
If Yes, please specify safety plan:

Referral Source	❑ Family Doctor	❑ Otolaryngologist	❑ Pediatrician	❑ Parent/Guardian
	❑ Public Health Nurse	❑ Audiologist/S-L Pathologist	❑ Social Worker	❑ Other _____

Name	Phone	Fax
Address *(including postal code)*		Signature

PLEASE COMPLETE ALL SECTIONS AND FAX THIS FORM TO 604-659-1109

Referral Returned *(office use only)*

- ❑ Hearing previously assessed – normal– date: _____
- ❑ No response/appointment declined by family
- ❑ CHA# _____
- ❑ Patient did not show for appointment date: _____
- ❑ Patient does not reside in health region
- ❑ PARIS ID# _____