

Please complete all sections of form. Incomplete referrals will be returned.					
Referral Date (dd/mmm/yyyy)	Personal Health Number	Gender	Primary Language	Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> Request for Speech-Language (0 to 5 years)	<input type="checkbox"/> Request for Audiology (0 to 19 years)
<p>Children are eligible if they live in Vancouver</p> <p>Reason for Referral</p> <p><input type="checkbox"/> Difficult to understand</p> <p><input type="checkbox"/> Few spoken words for age</p> <p><input type="checkbox"/> Difficulty forming sentences</p> <p><input type="checkbox"/> Difficulty understanding and responding</p> <p><input type="checkbox"/> Query Autism or developmental delay</p> <p><input type="checkbox"/> Child referred for Autism assessment: _____</p> <p><input type="checkbox"/> Behaviour (e.g. impulsive, difficulty socializing, aggression, tantrums)</p> <p><input type="checkbox"/> Stutters/repeats sounds and words</p> <p><input type="checkbox"/> Voice problem (e.g. hoarse voice, nasal sounding)</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p>_____</p> <p>_____</p> <p>Child Care Facility Attended: _____</p> <p><input type="checkbox"/> Daycare <input type="checkbox"/> Preschool</p> <p>Date Entered Facility: _____</p>	<p>Rule out hearing loss</p> <p><input type="checkbox"/> Parental concern</p> <p><input type="checkbox"/> School concern</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>Regular request for Audiology Assessment</p> <p><input type="checkbox"/> Suspected or known hearing loss</p> <p><input type="checkbox"/> Middle ear</p> <p><input type="checkbox"/> Pre/post surgery audiogram</p> <p><input type="checkbox"/> Issuance of hearing aids as needed</p> <p>Other risk factor for hearing loss, specify: _____</p> <p>Urgent request for Audiology Assessment</p> <p><input type="checkbox"/> Sudden onset hearing loss (not related to middle ear fluid/infection)</p> <p><input type="checkbox"/> Ear and/or head trauma, specify: _____</p> <p><input type="checkbox"/> Lab proven infection <i>with high risk of hearing loss</i>:</p> <p> <input type="checkbox"/> Meningitis</p> <p> <input type="checkbox"/> Cytomegalovirus (CMV)</p> <p>Other, specify: _____</p> <p>_____</p>

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

Referral Source	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Otolaryngologist	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Parent/Guardian
	<input type="checkbox"/> Public Health Nurse	<input type="checkbox"/> Audiologist/S-L Pathologist	<input type="checkbox"/> Social Worker	<input type="checkbox"/> 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)	
<input type="checkbox"/> Hearing previously assessed – normal– date: _____	<input type="checkbox"/> Patient did not show for appointment date: _____
<input type="checkbox"/> No response/appointment declined by family	<input type="checkbox"/> Patient does not reside in health region
<input type="checkbox"/> CHA# _____	<input type="checkbox"/> PARIS ID# _____