

# Referral for Hearing Services



## Patient details:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Pension number: \_\_\_\_\_

## Please conduct the following:

- Hearing Assessment (patients over 5 years of age)
- Air Conduction  Tinnitus Management
- Air and Bone Conduction  Custom-made Plugs
- Speech Discrimination  Hearing Loss Solutions
- Tympanometry
- Other \_\_\_\_\_

Are there contraindications to the fitting of a hearing device?

- Yes (May still be eligible for other hearing services)  No

## Clinic notes:

---

---

---

---

## Doctor details:

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Clinic name: \_\_\_\_\_

Provider number: \_\_\_\_\_

Stamp details here