SONARIS
EAR CENTER

REQUEST FOR AUDIOLOGICAL SERVICES

PEDIATRIC (0-19 Years) ☐ | Adult (Over 19 Years) ☐

Referral Date (dd/mm/yyyy) / / | Personal Health Number

Name | Date of Birth (dd/mm/yyyy) / / | Sex ☐ Male ☐ Female

Address | Postal Code

Parent/Guardian (If Applicable)

Home Phone | Cell Phone | Work Phone

Family Physician's Name

CHECK ALL THAT APPLY

- ☐ Hearing Concern
- ☐ Speech Concern (Rule out hearing loss.)
- ☐ Ear Trauma
- ☐ Pre/Post Surgery Audiogram
- ☐ Swim Molds/Hearing Protection
- ☐ Dizziness/Vertigo
- ☐ Tinnitus (Ringing in the ears.)
- ☐ Behavior (e.g. aggression, tantrums, impulsiveness, difficulty with social skills)
- ☐ Other, specify: _____

_____

_____

_____

SPECIALIZED TESTS/PROCEDURES

- ☐ Auditory Processing Evaluation
- ☐ Balance Function Assessment
- ☐ Cerumen Management (Patient must be at least 4 years old.)
- ☐ Hearing Aid Evaluation/Fitting
- ☐ Tinnitus Assessment

REFERRAL SOURCE

☐ Family Doctor	☐ ENT	☐ Pediatrician	☐ Parent/Guardian
☐ Public Health Nurse	☐ Speech-Language Pathologist	☐ School/Teacher	☐ Other, Specify

Name | Phone | Fax

Address | Postal Code

SIGNATURE

OFFICE USE ONLY

Passed NBHS ☐ Yes; ☐ Yes, /c R/F ( ); ☐ No; ☐ Declined; ☐ No Record

Appointments ☐ PRIORITY

☐ Hearing Test; 30 min / 45 min Assist ☐ Y ☐ N

☐ VNG (60 min)
☐ Caloric (60 min)
☐ VEMP (60 min)
☐ VHIT (60 min)

☐ Hearing Aid Evaluation/Fitting; Length 60 min / 90 min / 120 min Assist Y N ☐ ☐

☐ APD (120 min)

☐ Tinnitus (120 min)

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