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	☐ Hearing Aid Evaluation/Fitting; Length 60 min / 90 min / 120 min Assist ☐ Y ☐ N	
☐ VNG (60 min)	☐ APD (120 min)	☐ Tinnitus (120 min)
☐ Caloric (60 min)		
☐ VEMP (60 min)		
☐ VHIT (60 min)		

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