



Religious Hospitallers
of Saint Joseph
of the Hotel Dieu of Kingston

HOTEL DIEU HOSPITAL

DEPARTMENT OF AUDIOLOGY
144 Brock St., Murray Building

REFERRAL FORM

Phone: 613-546-3382, Fax: 613-544-5280
Website: <http://www.hoteldieu.com/audiology.html>

CR #:
Patient Name:
Date of Birth:
Address:

Postal Code:
Phone # – Home:
Alternate:
HN #:

Family Physician:
Referring Physician:
Physician's Fax:
Physician's Address:

Date of Referral: _____
yyyy/mm/dd

The following boxes must be check marked before an appointment will be booked:

- Yes, the patient is able to provide consent. If no, please ensure a SUBSTITUTE DECISION MAKER or a SIGNED CONSENT accompanies the patient.**
- Ear canals free of wax**
- * **Veterans Affairs Canada/ Dept. of National Defence (VAC/DND)** (Bring Blue Cross card)
- * **Workplace Safety and Insurance Board (WSIB)** (Bring claim number and Social Insurance Number)

Please Check All Desired Assessment(s) and Fax This Form to 613-544-5280

- Audiology Assessment – OHIP Covered
- Auditory Brainstem Response Test – OHIP Covered
- Hearing Aid Evaluation – \$75.00 Fee
- Hearing Aid Follow Up Only – \$50.00 Fee
- VNG/ENG (Vestibular Testing) – OHIP Covered (*Completed Requisition Required*)
- Employment Audiogram – Please bill _____

Please Check Presenting Symptoms:

- Hearing Loss
- Tinnitus
- Middle Ear Dysfunction
- Noise Induced Hearing Loss (patient must be out of noise **12 hours** prior to appointment)
- Other: _____
- Mobility or Vision Problems _____

Appointment Date: _____
yyyy/mm/dd

Appointment Time: _____
hh:mm

Please inform your patient of the appointment time and remind them to bring their health card.