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

Date of Referral: _____
yyyy/mm/dd

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

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

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

This patient requires an Interpreter ASL ☐ Language ☐_____ .

The following boxes must be checked 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: _____ **Appointment Time**: _____
yyyy/mm/dd hh:mm