Health PEI Santé Î.-P.-É.

Adult Audiology Referral

Name:	**Date of Birth:** (dd/mm/yyyy)	**Personal Health Number:** (Health Card)
Home Telephone:	**Work Telephone:**	
Cell Telephone:	Please circle the number we could reach you during the day.	
Address:	**Email:** Can we contact you by e-mail: ☐ Yes ☐ No	
Emergency Contact:		

Reason for referral (Check all that apply):

☐ Sudden onset hearing loss ☐ Rule out retrocochlear pathology ☐ Hearing loss in one ear

☐ Suspected hearing loss ☐ Ototoxic medications/monitoring ☐ Tinnitus

☐ At risk/has had noise exposure ☐ WCB or VAC (DVA) claim ☐ Head or ear trauma

☐ Trouble understanding/telling sounds apart (Auditory Processing problem) ☐ Other: _____

Medical Information/Additional Comments:

Other Services Involved (check all that apply):

☐ SLP ☐ Ear, Nose and Throat (ENT) ☐ Neurologist ☐ Physiotherapy

☐ Physician or other Medical Specialist ☐ Other: _____

Referred By:	**Telephone:**	**Fax:**
Address of Referral Source:		**Date:**

Provincial Audiology Program Contact

Audiology Health PEI **161 St. Peters Road** **Sherwood Business Center 2nd Floor** **PO Box 2000** **Charlottetown, PE C1A 7N8**	**T. 902 368 5807** **F: 902 620 3195** **Toll Free: 1 844 344 8255** **speechandhearing@ihis.org**

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