BC CHILDREN'S HOSPITAL
An Agency of the Provincial Health Services Authority

Audiology and Speech Language Pathology Department

COCHLEAR IMPLANT REFERRAL FORM

Phone: 604-875-2345 ext 7723

REFERRAL SOURCE:_____ TELEPHONE: _____

ADDRESS:_____

I. CHILD'S NAME: _____ D.O.B: _____ SEX: _____

BCCH UNIT NUMBER: _____ P.H.N. _____

PARENT/GUARDIAN NAMES: _____ TELEPHONE: _____

ADDRESS: _____ CITY: _____ POSTAL CODE _____

LANGUAGE MOST OFTEN SPOKEN: _____ INTERPRETER REQUIRED: YES NO

HAS THE PARENT/GUARDIAN BEEN NOTIFIED PRIOR TO REFERRAL? ☐YES ☐NO

FAMILY PHYSICIAN: _____ TELEPHONE:_____

AUDIOLOGIST: _____ TELEPHONE:_____

EARLY INTERVENTIONIST/HEARING RESOURCE TEACHER: _____ TELEPHONE:_____

PRESCHOOL/SCHOOL: _____ PRIMARY MODE OF COMMUNICATION: _____

DATE OF HEARING LOSS DIAGNOSIS: _____ DATE HEARING AIDS FIT: _____

CONSISTENCY OF HEARING AID USE: _____ ETIOLOGY: _____

II. REASON FOR REFERRAL:

- ☐ **PLEASE ENCLOSE ALL AUDIOLOGY RESULTS INCLUDING ABR WAVEFORMS**
- ☐ **PLEASE ENCLOSE ALL AVAILABLE INTERVENTION/HABILITATION REPORTS**
- ☐ **PHYSICIAN REFERRAL TO DR. KOZAK COMPLETED**
- ☐ **BEST REFERRAL COMPLETED (IF APPLICABLE)**

PLEASE EITHER: (1) Fax to (604) 875-2977
(2) Mail to B.C. Children's Hospital, Cochlear Implant Services
Room 1D20, 4480 Oak Street, Vancouver, BC V6H 3V4.

INTERNAL REFERRALS – FAX 2977