BCCH AUDIOLOGY REFERRAL

Children's Hearing Assessment

Date received stamp
(Office use only)

BCCH AUDIOLOGY ACCEPTS REFERRALS FOR THE FOLLOWING – CHECK BOX BELOW:

☐ BCCH Interdisciplinary Teams & Programs ☐ BCCH Inpatients ☐ Secondary Assessments – physician referral required and prior audiological assessment must have been attempted at local Public Health Audiology clinic **MANDATORY** – submit all previous audiologic test results	Direct all other referrals to local Public Health Audiology clinics www.phsa.ca/earlyhearing

Incomplete referrals will be returned.

Referral Date: (dd/mm/yyyy)

Patient Information

Patient Last Name	**Patient First Name**	**Patient Date of Birth** dd/mm/yyyy

BC PHN	**BCCH MRN** P	**Gender** ☐ Male ☐ Female ☐ Other

Parent/Guardian Name(s)	**Language** ☐ English ☐ Other:	**Check if Interpreting Required?** ☐

Address

Building Number Street Name Suite/Apt Number City/Town Province Postal Code

Phone

Is this child an inpatient?

☐ No ☐ Yes → Inpatient Ward & Local:

Approximate Discharge Date:

Referral Source – (*mandatory - complete section below or attach office letterhead)*

☐ **BCCH Physician** ☐ **ENT** ☐ **External Physician / Pediatrician / Physician**

Last Name	**First Name**	**Phone**	**Fax**

Address

Building Number Street Name Suite/Apt Number City/Town Province Postal Code

BILLING NO.

Type of Hearing Test - Complete ALL relevant boxes

☐ Behavioral Audiology (Hearing) Assessment

☐ UN-SEDATED Auditory Brainstem Response Test (<6 months of age)

☐ SEDATED Auditory Brainstem Response Test (≥6 months of age)

Reason for Referral

Provisional Diagnosis and Pertinent History

FAX COMPLETED FORM TO 604-875-2743.

AUDIOLOGY DEPARTMENT | Area 9. Room K2-191, 4480 Oak Street, Vancouver, BC, V6H 3V4 Tel**: 604-875-2112**