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	Gender
		☐ Male ☐ Female ☐ Other

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

Address	Phone

Is this child an inpatient?

☐ No ☐ Yes → Inpatient Ward & Local:

Approximate Discharge Date:

Referral Source – (*mandatory*)

☐ **BCCH Physician** ☐ **ENT** ☐ **Physician** **BILLING NO.**

Last Name	First Name	Phone	Fax

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

- ☐ Meningitis
- ☐ Other →
- ☐ cCMV

Provisional Diagnosis and Pertinent History

FAX COMPLETED FORM TO 604-875-2743.

AUDIOLOGY DEPARTMENT | Area 9. Room K2-192, 4480 Oak Street, Vancouver, BC, V6H 3V4 Tel**: 604-875-2112**