BCCH AUDIOLOGY REFERRAL

4480 Oak Street, Vancouver, BC V6H 3V4
Ambulatory Care Building, Area 9
Fax: 604-642-8837 **Phone:** 604-875-2112

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 attempted at local Public Health Audiology clinic. Submission of all previous audiologic test results is **MANDATORY.**	Direct all other referrals to local Public Health Audiology clinics http://www.phsa.ca/earlyhearing

INCOMPLETE REFERRALS WILL BE RETURNED

Referral date (dd/mm/yyyy)

Patient information

Last name	**First name**	**DOB** (dd/mm/yyyy)	**BC PHN** (care card)

Gender (as indicated on the patient's care card)	**Language**	**Interpreter required?** ☐ **No** ☐ **Yes**
☐ **Female** ☐ **Male** ☐ **Other**	☐ **English** ☐ **Other**	**Language**

Mailing address (number/street/apt.)	**City/Town**	**Postal code**

Is this child an inpatient? ☐ **No** ☐ **Yes**	**If yes:** Inpatient ward & local:	Approx. discharge date

Parent(s), legal guardian(s) and/or caregiver(s)

Last name	**First name**	**Relationship**	**Phone**	**Email**	**Legal guardian?**
					☐ **Yes**
					☐ **Yes**

Referral source (mandatory) (complete section below *or* attach office letterhead)

☐ BCCH physician ☐ ENT ☐ External GP/pediatrician ☐ NP

Last name	**First name**	**MSP billing #**

Phone	**Email**	**Fax**

Mailing address (number/street/apt.)	**City/Town**	**Postal code**

Reason for referral & recommendation (please attach extra pages if more space is needed)

☐ **cCMV** ☐ **Meningitis**

☐ **Behavioural Audiology Hearing Assessment**

☐ **Unsedated Auditory Brainstem Response (<6 mo age)**

☐ **Sedated Auditory Brainstem Response (>6 mo age)**

Provisional diagnosis & pertinent history (please attach extra pages if more space is needed)

FAX COMPLETED FORM TO 604-642-8837

Last Updated: August 2, 2023