



NOVA SCOTIA HEARING AND SPEECH CENTRES

REFERRAL

Hospital card imprint

<p>Name: Last _____</p> <p>First _____ Middle _____</p> <p>Date of Birth: ____/____/____ Sex: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Address: _____</p> <p>Apt. #: _____ City: _____</p> <p>Province: _____ Postal Code: _____</p>	<p>Health #: _____</p> <p>Province: NS <input type="checkbox"/> or _____ Expiry Date: ____/____/____</p> <p>Next of Kin: _____ Tel: _____</p> <p>RCMP #: _____ Other or Country Name: _____</p> <p>VAC-TAPS #: _____ Armed Forces #: _____</p> <p>Has this patient been seen previously by the NSHSC? Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Where: _____ Chart #: _____</p>
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<p>FAMILY DOCTOR</p> <p>Name: _____</p> <p>Address: _____</p> <p>Postal Code: _____ Tel: _____</p>	<p>REFERRAL SOURCE: _____</p> <p>Company/Agency Name: _____</p> <p>Address: _____</p> <p>Postal Code: _____</p> <p>Tel: _____ Date: _____</p>
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REFERRAL FOR:

<input type="checkbox"/> Complete Hearing Evaluation	<input type="checkbox"/> Speech-Language Evaluation
<input type="checkbox"/> Hearing Screening	<input type="checkbox"/> Voice Evaluation
<input type="checkbox"/> Hearing Aid Evaluation	<input type="checkbox"/> Fluency (Stuttering) Evaluation
<input type="checkbox"/> * AEP: ABR <input type="checkbox"/> MLR <input type="checkbox"/> LLR (cortical) <input type="checkbox"/> ECoG <input type="checkbox"/>	<input type="checkbox"/> Dysphagia (Swallowing) Evaluation (where available)
<input type="checkbox"/> Other: _____	

* A current audiogram is required. If possible, include results from Immittance, Reflex Decay, and PIPB Function.

Are these services required for employment, insurance or pension purposes: YES NO If so, why?

SYMPTOMS/REASON FOR THIS REFERRAL:

Is there any medical contraindication to performing a hearing aid evaluation? YES NO If so, what?

You may not refer to a specialist in Otolaryngology:

Any special procedures for this case?

<p>OFFICE USE ONLY</p> <p>Institute/Chart #: _____ Active: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Site Forwarded to: _____ Date: _____</p> <p>Date Case History Form Mailed to Patient: _____</p> <p>Dates Called etc./Results/Comments: _____</p>	<p>Referral Code: _____ Payment Resp. Code: _____</p> <p>Visit Cost/Reason \$ _____</p> <p>Appt. Date/Time: _____</p> <p>Type: _____ Clinician: _____</p> <p>Date Received: _____</p>
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