THE EAR & AUDIOLOGY CLINIC

Audiology Referral Form

Referring Physician / Health Professional Name: _____

e-mail: _____ Date: _____

Phone: _____ Fax: _____

Client Information:

Client Name: _____ D.O.B.: _____

Cellphone: _____ Home Phone: _____ Gender: M F

e-mail address: _____

Reason for Referral:

☐ Hearing Test ☐ Hearing Aid Evaluation ☐ Tinnitus

☐ Hearing Aid Services ☐ Ear Wax Removal ☐ Consultation

☐ Custom Ear Plugs *(swimming, hearing protection, musicians, etc...)*

Any additional notes about the client:

☐ **3630 Lawrence Ave E, Unit 201, Scarborough, Ontario, M1G 1P6**

☐ **174 Athol St E, Suite B, Oshawa, Ontario, L1H 1K1**

☐ **500 University Ave, Unit 5, Toronto, Ontario, M5G 1V7, Rehabilitation Sciences Bldg** (UFT) (Satellite location)

Please send us the completed form by:

e-mail: **contact@earandaudiologyclinic.ca**
earandaudiologyclinic@gmail.com

Fax: **647-277-9001**

If you have any questions, please call us at:
647-812-1151

Thanks for your trust in us!

In clinical affiliation with the University of Toronto