



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

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!