NOVA SCOTIA HEARING AND SPEECH CENTRES

REFERRAL

c/o Queen Square
45 Alderney Drive, Suite 803, Dartmouth, NS B2Y 2N6
Tel: 902/464-3084 Fax: 902/464-9440
http://www.NSHSC.ns.ca

Hospital card imprint

Name: Last *Sample*
First *Patient* Middle *Beta*
Date of Birth: *14* / *3* / *1982* Sex: M ☐ F ☒
Address: *123 Main St.*
Apt. #: *218* City: *Dartmouth*
Province: *NS* Postal Code: *B2B2B2*
Tel: (H) *(902) 555-0248 work* (W) *(902) 555-1729 cell*

Health #: *0001000009*
Province: NS ☒ or _____ Expiry Date: *3* / *3* / *2018*
Next of Kin: *,Johnny Test* Tel: *(902) 555-0319*
RCMP #: _____ Armed Forces #: _____
Other or Country Name: _____
Has this patient been seen previously by the NSHSC? Y ☒ N ☐
Where: *Dartmouth* Chart #: *1036664*

FAMILY DOCTOR
Name: *Dr. FAMILY PHYSICIAN*
Address: *Family Doctor Clinic 456 Main St.*
Suite 200 HALIFAX, NS
Postal Code: *B2B 2B2* Tel: *(902) 555-0329*

REFERRAL SOURCE: *DR. REFERRING PHYSICIAN*
Company/Agency Name: *Test Clinic 18*
Address: *123 Any St., Suite 147*
Halifax, NS Postal Code: *B1B 1B1*
Tel: *(902) 555-5555* Date: *14/07/2014*

Are there any special procedures for this case (e.g., for booking appointments or completion of case history form)?

REFERRAL FOR:

- ☒ Complete Hearing Evaluation
- ☐ Hearing Screening
- ☐ Hearing Aid Evaluation
- ☐ *** AEP**: ☐ ABR ☐ MLR ☐ LLR (cortical) ☐ ECoG
- ☐ Speech-Language Evaluation
- ☐ Dysphagia (Swallowing) Evaluation (where available)
- ☐ Other: _____

*** A current audiogram is required.** If possible, include results from Immittance

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

SYMPTOMS/REASON FOR THIS REFERRAL: ***Etiam gravida, orci a elementum porta, sapien erat bibendum purus, id pretium erat metus eget purus. Phasellus scelerisque vestibulum sem pellentesque sagittis. Sed mollis libero a nisi elementum, ac semper augue varius. In tortor orci, pulvinar at lobortis et, pulvinar sit amet erat.***

ALERTS:

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

You may refer to a specialist in Otolaryngology: ☒ YES ☐ NO

Does client have accessibility or cultural considerations (e.g., mobility, vision, literacy, non-English speaker)? ☐ YES ☒ NO
If yes, please describe:

OPTIONAL:

I agree to the following person receiving information about my Hearing/Audiology and/or Speech-Language Pathology appointment:
_____ (name / position / relationship)
_____ (phone / address)
Client Name: _____ Date: / /