Alberta Health Services

Place Label Here

Community Audiology Services Request
Edmonton Zone

Central Access
Phone: 780.735.3489
Fax: 780.670.3235

Please fill out all sections of form. Incomplete referrals will be returned.

(Please note: For under 6 months of age, please refer to the Glenrose Rehabilitation Hospital or the University of Alberta and Stollery Children's Hospital using form CH-0787 Audiology Service Consultation Request (http://www.albertahealthservices.ca/frm-ch-0787.pdf)

Patient's Name	Date of Birth *(yyyy-Mon-dd)*	PHN
Address		Postal Code
Mother	Father	Guardian *(if applicable)*
Home Phone	Work Phone	Cell Phone
Interpreter required? ☐ No ☐ Yes ☐ Language _____		Physician Name

☐ **Routine Audiological assessment** *(please include the most recent Audiological report, if applicable)*

If the client is 3 to 18 years of age, please check all that apply:

- ☐ Diagnosed/suspected Autism OR very low cognitive function
- ☐ Diagnosed/suspected syndrome with possibility of hearing loss.
- ☐ Diagnosed PERMANENT hearing loss
- ☐ Atresia
- ☐ Recent meningitis

☐ **SUDDEN hearing loss** (Rapid onset of hearing loss in the past 72 hours with no identifiable cause. If hearing loss occurred more than 72 hours ago, check *Routine Audiological assessment*)

☐ **Failed hearing screening** *(please include the screening report)*

☐ **EHDI: Passed hearing screening and requires follow up at 6 mo. adjusted age**
(Birth gestational age in weeks_____)

☐ **Pre-ENT surgery**
Surgery date _____ Type of surgery _____

☐ **Hearing concern during CURRENT ototoxic treatment**
Ototoxic agents _____

Referral Source

Name	Location	
Phone	Fax	Referral Date