



# REQUEST FOR SERVICES - PROVIDER Community Pediatric Audiology Program



Patient Reviewed

**Please complete all sections of this form. Incomplete referrals might be returned.**

Referral Date (dd/mm/yyyy)		Personal Health Number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	
Child's Name (surname, first name)		Preferred name		Date of Birth (dd/mm/yyyy)      Age	
Address				Postal Code	
Can attend short notice appointment. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Parent or Guardian Name			Parent or Guardian Name		
Primary Phone		Secondary Phone		Email address	
Name of School			Language spoken at home: <input type="checkbox"/> English <input type="checkbox"/> Other, specify:		Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Doctor or Nurse Practitioner Name:			Does family identify as First Nations, Metis or Inuit? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Who is making this referral?**

<input type="checkbox"/> Audiologist or Speech-Language Pathologist	<input type="checkbox"/> Family Doctor or Nurse Practitioner	<input type="checkbox"/> Public Health Nurse
<input type="checkbox"/> ENT	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Other, specify:
Name	Phone	Fax

**Reason for referral**

**Please check all boxes that apply to the child and provide as much detail as possible.**

<b>Rule out hearing loss</b> <input type="checkbox"/> Parental concern <input type="checkbox"/> School concern <input type="checkbox"/> Speech delay <input type="checkbox"/> Other, specify:	<b>Urgent request for Audiology Assessment</b> <input type="checkbox"/> Sudden hearing loss (not related to middle ear fluid or infection) <input type="checkbox"/> Ear or head trauma, specify: <input type="checkbox"/> Lab proven infection with high risk of hearing loss: <input type="checkbox"/> Meningitis <input type="checkbox"/> Cytomegalovirus (CMV) <input type="checkbox"/> Other, specify:
<b>Regular request for Audiology Assessment</b> <input type="checkbox"/> Suspected or known hearing loss <input type="checkbox"/> Middle ear <input type="checkbox"/> Pre or post-surgery audiogram <input type="checkbox"/> Other risk factor for hearing loss, specify:	

**Concerns for autism or developmental delay?**     Yes  No

**If yes, has the child been referred for autism assessment?**     No  Sunny Hill  Private:

**REQUEST FOR SERVICES - PROVIDER**  
**Community Pediatric Audiology Program**

Please fax referrals to audiology service locations and identify the clinic below.

**Audiology Services**

Clinic	Fax	Phone
<input type="checkbox"/> <b>Abbotsford</b> 104 - 34194 Marshall Road B.C. V2S 5E4	604-864-3410	604-864-3468
<input type="checkbox"/> <b>Burnaby</b> 105 - 4946 Canada Way Burnaby B.C. V5G 4H7	604-918-7660	604-918-7663
<input type="checkbox"/> <b>Chilliwack</b> 45470 Menholm Road Chilliwack B.C. V2P 1M2	604-702-4971	604-702-4944
<input type="checkbox"/> <b>Surrey - Guildford</b> 100-10233 153 Street Surrey B.C. Postal Code V3R 0Z7	604-587-4777	604-587-4751
<input type="checkbox"/> <b>Langley, Cloverdale, and White Rock</b> 110 - 6470 201 Street Langley B.C. V2Y 2X4	604-530-8138	604-539-2904
<input type="checkbox"/> <b>Maple Ridge and Mission</b> 400 - 22470 Dewdney Trunk Road Maple Ridge B.C. V2X 5Z6	604-476-7077	604-476-7070
<input type="checkbox"/> <b>New Westminister, Port Moody, Coquitlam and Port Coquitlam</b> 236 - 610 Sixth Street New Westminister B.C. V3L 3C2	604-525-3803	604-777-6855
<input type="checkbox"/> <b>North Delta</b> 11245 84 Avenue Delta B.C. V4C 2L9	604-591-7382	604-507-5440

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