

# Children<sup>a</sup>s Treatment Centre of Chatham-Kent

355 Lark Street, Chatham, Ontario N7L 5B2 Tel (519) 354-0520 Fax (519) 354-7355

## Adult Audiology Self Referral Form

Date: \_\_\_\_\_ Referral Source:  Self  Other:

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_

HC#: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Audiology Services Requested:  Audiology  Hearing Aid Evaluation

Reason for Referral: \_\_\_\_\_

Other Agencies Involved: \_\_\_\_\_

Has your hearing been tested before? \_\_\_\_\_

Do you have an identified hearing loss? \_\_\_\_\_

Is this a sudden hearing loss? \_\_\_\_\_

Do you wear a hearing aid? \_\_\_\_\_

Do you have any of the following? /Check those that apply:

- Ringing in the ears  Ear Pain  Ear infections  
 Draining from ears  Plugged/fullness sensation in ears  
 Excessive wax removed by doctor  Ear, nose or throat surgeries  
 Dizziness/balance difficulties  Accidents/head injuries

Comments: \_\_\_\_\_

Completed by: \_\_\_\_\_  Cancellation List

\*Assessment fee of \$72.00 is due at time of assessment