

# 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

## Children's Services - Self Referral Form

Date: \_\_\_\_\_ Referral Source:  Parent  Other: \_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Male  Female

Parent Name: \_\_\_\_\_

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

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

Family Physician: \_\_\_\_\_ Paediatrician: \_\_\_\_\_

Services Requested:  Audiology  CAP (6-13 yrs)

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

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

Has your child ever had a hearing test? \_\_\_\_\_

Does your child have an identified hearing loss? \_\_\_\_\_

Does your child wear hearing aids? \_\_\_\_\_

Has your child had any of the following

Ear infections  p.e./ear tubes  Ear, nose, throat surgeries

Excessive wax removed by doctor  ear pain

Is there a family history of permanent hearing loss from birth or childhood?

Yes  No If yes, please explain: \_\_\_\_\_

Completed by: \_\_\_\_\_

Cancellation List