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Fraser Health
Acute Audiology Services
32900 Marshall Road, Abbotsford, BC V2S 0C2
Phone: 604-851-4700 / Fax: 604-851-4872

Audiology Outpatient Referral Form

Abbotsford Regional Hospital

Date of Referral:	**Referring Physician *(Specialists Only)***
Patient Name:	Name:
Patients must reside in the FH catchment area	Address:
PHN:	Phone #:
D.O.B.:	Fax #:
Home #:	**Family Physician *(Please include)***
Cellular #:	Name:
Address:	Phone #:
	Fax #:
Symptoms / Diagnosis / Reason for Referral:	

☐ **COMPREHENSIVE AUDIO** - Includes pure tones, speech, immittance, otoacoustic emissions (OAEs).

☐ **ADULT RETROCOCHLEAR AUDITORY BRAINSTEM RESPONSE (ABR) EVALUATION**

☐ **PAEDIATRIC THRESHOLD AUDITORY BRAINSTEM RESPONSE (ABR)** - **sedated / unsedated**
Chloral hydrate sedation generally is required for infants over 3 months' corrected age. Referring physicians with attending privileges please complete the ***Oral Procedure Sedation "Standard Orders" and return with referral.***

☐ **ADULT CENTRAL AUDITORY PROCESSING (CAPD) EVALUATION**

☐ **PAEDIATRIC (8 YRS+) CENTRAL AUDITORY PROCESSING (CAPD) EVALUATION**

☐ **VESTIBULAR EVALUATION** Please indicate if either of the following is applicable:
- ❑ Perforated tympanic membrane
- ❑ Neck/back/hip injury or pain

PLEASE FAX THE FOLLOWING TO (604) 585-5568:

☐ This form
☐ Most recent audiogram
☐ Consult Letter
☐ Vestibular Questionnaire, if applicable
☐ "Standard Orders", if applicable