

Audiology Outpatient Referral Form

Surrey Memorial Hospital

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

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|---|---|
| <input type="checkbox"/> This form
<input type="checkbox"/> Most recent audiogram
<input type="checkbox"/> Consult Letter | <input type="checkbox"/> Vestibular Questionnaire, if applicable
<input type="checkbox"/> "Standard Orders", if applicable |
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