Fraser Health
Acute Audiology Services
32900 Marshall Road, Abbotsford, BC V2S 0C2
Phone: 604-851-4700 ext. 646997 / Fax: 604-851-4872

Audiology Outpatient Referral Form

Abbotsford Regional Hospital

Date of Referral:	**Referring Physician** ***(Specialists ONLY)***
Patient Name:	Name:
PHN:	Address:
DOB:	
Address	Phone #:
Patients must reside in the FH catchment area*	Fax #:
Contact Info (Required)	**Family Physician** ***(Please include)***
Home #:	Name:
Cellular #:	Phone #:
	Fax #:
Email:	**Reason for Referral**:
Interpreter Required?	
Y / N Language:	

☐ **Comprehensive Audiological Assessment**
- ❑ Adult
- ❑ Pediatric

☐ **Auditory Brainstem Response (ABR) Evaluation (Retrocochlear)**
- ❑ Adult
- ❑ Pediatric -- **sedated / unsedated**

For sedated ABRs, child must be 12 months of age or older. The referring physician, with attending privileges, must write orders in sedation (IN or PO route) and return with this referral.

☐ **Central Auditory Processing (CAP) Assessment**
- ❑ Adult
- ❑ Pediatric (8+ years)

☐ **Vestibular Assessment**

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