Reset Form

Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

Adult Audiology Referral

Name:	**Date of Birth**: (D/M/Y)	**Personal Health Number** (Provincial Health Card):
Home Telephone:	**Work Telephone:**	
Cell Telephone:	Please circle the number we could reach you during the day.	
Address:	**Email:** Can we contact you by e-mail: ☐ Yes ☐ No	
Emergency Contact:		

Reason for Referral:

☐ Sudden onset hearing loss ☐ Rule out retrocochlear pathology ☐ Unilateral hearing loss

☐ Head or ear trauma ☐ Ototoxic medications/monitoring ☐ Tinnitus

☐ At risk/has had noise exposure ☐ To initiate a WCB or VAC (DVA) claim

☐ Trouble understanding/telling sounds apart (Auditory Processing problem) ☐ Other

Medical Information/Additional Comments:

Other Services Involved:

☐ Ear Nose and Throat (ENT) ☐ Speech Language Pathologist ☐ Neurologist

☐ Physician or other Medical Specialist ☐ Other

Referred By:	**Telephone:**	**Fax:**
Address of Referral Source:		**Date:**

Provincial Audiology Program Contact	
Charlottetown **161 St. Peters Road** **PO Box 2000** **Charlottetown, PE C1A 7N8**	**T. 902 368 5807** **F: 902 620 3195** **Toll Free: 1 844 344 8255** **speechandhearing@ihis.org**

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