

Child Audiology Referral

Name:	Date of Birth: (dd/mm/yyyy)	Personal Health Number: (Health Card)
Home Telephone:		Work Telephone:
Cell Telephone:		
Name of Parent/Guardian/Contact:		Address:
Email:		Family Physician:
Languages Spoken: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____		
I am requesting a Hearing Test (Check all concerns that apply):		
<input type="checkbox"/> Speech delay <input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Family history of hearing loss (sibling, parent, or cousin)		
<input type="checkbox"/> Failed hearing screening <input type="checkbox"/> Academic/learning difficulties		
<input type="checkbox"/> Shows behavior suggesting hearing loss, please describe: _____		
I am requesting an Auditory Processing Test (for a child over 7 years of age) (Check all concerns that apply):		
<input type="checkbox"/> Poor listening, difficulty following spoken directions <input type="checkbox"/> Doesn't take part in conversations		
<input type="checkbox"/> Short attention span or memory problems <input type="checkbox"/> Easily distracted/disorganized		
<input type="checkbox"/> Finds reading/writing/spelling unusually difficult <input type="checkbox"/> Bothered by loud/sudden noises or noisy places		
<input type="checkbox"/> Difficulty hearing words correctly; especially in noise <input type="checkbox"/> Ability to hear and behavior is better in a quiet environment		
Other Services Involved (Check all that apply):		
<input type="checkbox"/> SLP <input type="checkbox"/> Ear, Nose and Throat (ENT) <input type="checkbox"/> Pediatrician <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Other: _____		
Has hearing been screened/tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Results:		
Pure Tone <input type="checkbox"/> Yes <input type="checkbox"/> No		
Questionnaire <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Information:		
Referred by: Telephone: Date:		

Provincial Audiology Program Contact

Audiology Health PEI 161 St. Peters Road Sherwood Business Center 2 nd Floor 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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