Reset Form

Health PEI
One Island Health System

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

Pediatric Audiology Referral

Name:	**Date of Birth: (D/M/Y)**	**Personal Health Number** (Provincial Health Card):
Home Telephone: **Cell Telephone:**	**Work Telephone:**	
Name of Parent/Guardian/Contact:	**Address:**	
Email:	**Would you like to be on a Cancellation list?** ☐ Yes ☐ No	**Family Physician:**

Languages Spoken: ☐ English ☐ French ☐ Other:

Reason for hearing test: (Check all that apply)

☐ Speech delay ☐ Frequent ear infections ☐ Family history of hearing loss

☐ Failed hearing screening ☐ Academic/learning difficulties

☐ Shows behavior suggesting hearing loss, please describe: _____

_____

☐ Shows behavior suggesting sound processing difficulties, please check all that apply: (For those over 7 years of age):

____ Poor listening, difficulty following spoken directions ____ Doesn't take part in conversations

____ Short attention span or memory problems ____ Easily distracted/disorganized

____ Finds reading/writing/spelling unusually difficult ____ Bothered by loud/sudden noises or noisy places

____ Difficulty hearing words correctly; especially in noise ____ Ability to hear and behavior is better in a quiet environment

Other Services Involved: (check all that apply)

☐ SLP ☐ Ear, Nose and Throat (ENT) ☐ Pediatrician ☐ Physiotherapy ☐ Other: _____

Has hearing been screened/tested? ☐ Yes ☐ No Date/Results:

Pure Tone ☐ Yes ☐ No

Questionnaire ☐ Yes ☐ No

Additional Information:

Referred by: _____ **Telephone:** _____ **Date:** _____

Personal health information on this form is collected by Health PEI for the purposes of your care and for other purposes permitted by the *Health Information Act*, including the planning and management of health services. Your information will be collected, used and disclosed only as permitted by law. For more information, visit www.healthpei.ca/yourprivacy or contact 1 844 344 8255.

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