sound advice
HEARING CLINIC

685 Sheppard Ave. E. Suite 402
North York, ON M2K 1B6
Phone: 416.398.5050 Fax: 416.398.6262

REFERRAL FORM

Referring Physician: _____ Billing No.: _____

Dr. Phone: _____ Dr. Fax: _____

Patient Name: _____ DOB (d/m/y): _____

Patient Phone (Primary): _____ (Secondary):_____

Patient Email: _____

Health Card Number:_____ Version Code:_____

Patient Address: _____

Reason for Referral

- ○ Hearing Test (Battery of tests will vary according to age)
- ○ Auditory Brainstem Response Test
- ○ Tinnitus Assessment and Counselling (private pay)
- ○ Hearing Aid Consultation
- ○ Hearing Aid Check
- ○ Custom-made noise and swim plugs
- ○ Other _____

Please specify any special considerations (e.g. developmental concerns, etc):

_____

_____

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Please note: There are 4 onsite Ear Nose & Throat physicians. If the patient also requires an ENT consult, a referral note may be faxed to 416.499.9392. The onsite ENTs are , Dr. Manish Shah, Dr. Thileep Kandasamy, Dr. Jason Xu, and Dr. Josie Xu

THANK YOU FOR THE REFERRAL!!