London Health Sciences Centre

Cochlear Implant Program
339 Windermere Rd. PO Box 5339
London, Ontario, Canada N6A 5A5
T: 519-685-8500 | F: 519-663-3916

Date: _____

Implantable Devices Referral Form:

☐ Cochlear Implant ☐ Bone Bridge

Select all that apply: ☐ Referral to Audiology ☐ Referral to Dr. L. Parnes/Dr. S. Agrawal/Dr. D. Bajin

Patient Information

Full Name: _____ Sex: _____
Last *First* *M.I.*

Address: _____
Street Address

_____
City *Prov.* *Postal Code*

Phone: _____
Home *Cell* *Work*

E-mail: _____

DOB: _____ Health Card Number: _____

Investigation

Please attach a copy of the most recent audiogram. If the patient has not had a hearing test within the last year, please ensure one is completed and sent with the referral.

Does the patient currently use hearing aid(s): ☐ YES ☐ NO

If yes, which ear(s): ☐ RIGHT ☐ LEFT ☐ BOTH

Etiology of hearing loss: _____

Age of onset of hearing loss: _____

Is an interpreter required? ☐ YES ☐ NO If yes, specify type _____

Has a CT/MRI of the temporal bones been completed? ☐ YES ☐ NO If yes, please attach copy

Referral Source

Referral Source

Name: _____ Specialty: _____

Address: _____ Phone number: _____

_____ Fax number: _____

Family physician *(if different from above)*

Name: _____

Address: _____ Phone number: _____

_____ Fax number: _____

SIGNATURE: _____ ***DATE:*** _____

**Please fax or mail this form to the number/address at the top of this form. Your patient will be contacted directly for an appointment. Thank you for this referral!*