Sunnybrook Health Sciences Centre
Cochlear Implant Program
Room M1-102, 2075 Bayview Ave.
Toronto, ON M4N 3M5
416-480-6751 (voice)
416-480-5761/416-480-4201 (fax)

PATIENT REFERRAL FORM (fax or mail form to the fax number or address above)
Please fill in as completely as possible

Last Name: _____ First Name, Initial: _____

Street Address: _____ Apt. #: _____

City: _____ Postal Code: _____

Phone: _____ Date of birth (YY/MM/DD): _____

Health Card #: _____ Version Code: _____

Sex: _____ First Language: _____

Audiometry (or attach a copy of most recent audiogram) Date of test (YY/MM/DD): _____

Frequency in Hertz (Hz)

	250	500	1000	2000	4000	WDS (%)
Right Ear (dB HL)						
Left Ear (dB HL)						

Does patient currently use hearing aid(s)?: Yes____ No____; If yes, which ear(s): Right____ Left____

Etiology of deafness: _____

Age of onset of severe – profound deafness (approximate in years): _____

Referral Source:

Name: _____

Address: _____

Specialty: _____ Physician's (6-digit) #: _____

Phone: _____ Fax #: _____

Family Physician (if different from above):

Name: _____

Address: _____

Physician's (6-digit) #: _____ Phone: _____

Your patient will be contacted directly for an appointment.

Thank you for this referral.

Sunnybrook
HEALTH SCIENCES CENTRE