Sunnybrook
HEALTH SCIENCES CENTRE

REFERRAL FORM

DEPARTMENT OF OTOLARYNGOLOGY

P: (416) 480-4138 F: (416) 480-5761

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____

OHIP #: _____ VERSION CODE: _____ DOB (YY/MM/DD): _____

ADDRESS: _____

_____

PHONE: HOME: (____) _____ WORK: (____) _____ CELL: (____) _____

EMAIL: _____

PHYSICIAN CONSULTATION REQUESTED:

OTOLOGY/NEUROTOLOGY:	☐ Dr. J. Chen	☐ Dr. V. Lin	☐ Dr. T. Le
HEAD & NECK SURGICAL ONCOLOGY:	☐ Dr. D. Enepekides	☐ Dr. K. Higgins	☐ Dr. A. Eskander
OTOLARYNGOLOGY:	☐ Dr. T. Kandasamy		
LARYNGOLOGY:	☐ Dr. R. J. Lin		
DIZZINESS CONSULTATION**:	☐ Yes ☐ No		

Dizzy / Vertigo referrals will only be accepted from Otolaryngologists, Neurologists, and Sunnybrook Family Medicine. All other referrals will be returned.

REASON FOR REFERRAL:

_____

_____

AUDIOLOGY APPOINTMENT(S):

CONSULTATION REQUESTED:

☐ Audiology Assessment ☐ Hearing Aid Evaluation ☐ Tinnitus Workshop

Does the patient require hearing aids? ☐ Yes ☐ No Does the patient have hearing aids? ☐ Yes ☐ No

☐ Auditory Brainstem Response (ABR) Otoneurologic / Site of Lesion)

☐ Electrocochleography (EcoG) ☐ cVEMP

☐ Vestibular ENG/VNG

Has the patient had Vestibular testing (ENG/VNG) before? ☐ Yes ☐ No (If yes, please attach copies of the report.)

REFERRING PHYSICIAN INFORMATION:

DOCTOR: _____ OHIP BILLING #: _____

ADDRESS: _____ PHONE: _____

_____ FAX: _____

***** If the patient has had prior imaging done, they must bring those images on a CD for the Physician to review on the date of their appointment. Failure to bring imaging may result in rescheduling of their appointment.***

****PLEASE NOTE:* WE ARE A SURGICAL PRACTICE ONLY!**