Welfare or ODSP Patients are 100% covered for hearing aids. Transportation and/or Home Visits can be arranged for ODSP patients

Patient Name: \_\_\_\_\_

| Phone Number:   |
|---|
| Please ensure patient ear canals are free of wax prior to appointment, Thank you. |
| Reason for Referral:  |
| Hearing Loss (Right , Left , Both )   |
| <b>Hearing Aid Consultation</b>   |
| Hearing Test/Evaluation   |
| Hearing Screening for Work Purposes   |
|   |
| Other Notes:  |
| Referring Physician:  |
| Physician Signature:  |
| late:   |