2705 Centre St. NW Unit E, Calgary AB T2E 2V5 &
#405, 9650 Harvest Hills Blvd NE, Calgary, AB, T3K 0B3
Tel: (403)680-2323 Fax: (403)226-8016

REFERRAL for HEARING TEST / HEARING AID PRESCRIPTION

PATIENT DETAILS

Name: _____ **Gender:** _____

Date of Birth (dd/mm/yyyy): _____ **Alberta PHN:** _____

Address: _____

Email: _____ **Phone:** _____

CLINICAL INDICATIONS

I have assessed the patient and would like to refer the patient to conduct the appropriate hearing test.

Reason for Referral (check all that apply):

- ☐ **Sudden hearing loss**
- ☐ **Occupational /noise exposure**
- ☐ **Eustachian tube dysfunction**
- ☐ **Hearing aid evaluation**
- ☐ **Tinnitus**
- ☐ **Note/History/Special instructions (complete below):**
- ☐ **Hearing assessment**
- ☐ **Vehicle license renewal**

_____

_____

_____

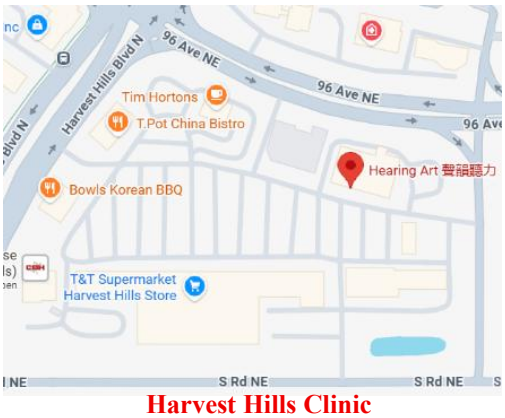
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☐ **Centre Street Clinic: Unit E, 2705 Centre Street NW, Calgary, AB, T2E 2V5**

☐ **Harvest Hills Clinic: #450, 9650 Harvest Hills Blvd NE, Calgary, AB, T3K 0B3**



Centre Street Clinic



Harvest Hills Clinic

REFERRING PHYSICIAN

Name: _____

Clinic: _____

Clinic Phone: _____ **Clinic Fax:** _____

Signature: _____ **Date:** _____