Audiology Department
Cochlear Implant Referral Form

REFERRAL SOURCE

☐ Audiologist ☐ ENT ☐ Family Physician ☐ Other_____		
Name:	**Telephone:**	**Fax:**
Address:		

CHILD'S HISTORY

Child's First Name:	**Middle Initial**	**Child's Last Name:**
Child's Date of Birth Month / Day / Year		**Child's first language:**
Health Card Number:		
Home address:		
What language(s) does the family speak at home?		
Is an interpreter required? ☐ No ☐ Yes – please state language_____		
Parent/Guardian names:	**Telephone:**	
Family Physician:	**Telephone:**	
Audiologist:	**Telephone:**	
Primary mode of communication: ☐ Spoken language ☐ Sign language ☐ Other_____		
Date of hearing loss diagnosis:	**Etiology:**	
Date of hearing aid fitting:	**Is parent/guardian aware of this referral?** ☐ No ☐ Yes	
Reason for referral:		

Please return the completed intake referral form, including a doctor's referral to CHEO ENT, copies of all available audiology reports, speech and language assessment reports and any other relevant reports from this child's care team to:

CHEO Cochlear Implant Program, Audiology
401 Smyth Road, Ottawa, Ontario, K1H 8L1
Tel: (613) 737-7600 Ext 2371
Fax: (613)738-4222